Office of the Inspector General

For the
Department of Mental Health,
Mental Retardation
And Substance Abuse Services

Semi - Annual Report
April 1 – September 30, 2002

COMMONWEALTH of VIRGINIA

Office of the Governor

Mark R. Warner
Governor

November 29, 2002

To the General Assembly of Virginia:

I have enclosed, as required by the Code of Virginia, the semi-annual report of the Inspector General regarding her inspections of mental health and mental retardation facilities in the Commonwealth. The purpose of these reviews is to identify opportunities for improvement in quality of care and to help promote continuous quality improvement in state mental health and mental retardation facilities.

I am very gratified that quality of care in Virginia's mental health and mental retardation facilities continues to improve. Care for the most vulnerable citizens is one of the hallmarks of a civilized society. The unannounced reviews conducted by the Office of the Inspector General have been helpful in improving this care.

I hope that each of you enjoyed a restful and happy Thanksgiving holiday. I look forward to working with each of you in continuing to improve the quality of care for Virginia's most vulnerable citizens.

Sincerely,

Mark R Warner

Mark R. Warner

MRW/wlm

C: The Honorable Jane H. Woods
Anita Everett, M.D.

COMMONWEALTH of VIRGINIA
Office of the Governor

Anita S. Everett, M.D.
Inspector General
to the Department of Mental Health, Mental Retardation
and
Substance Abuse Services

December 2, 2002

To the General Assembly of Virginia:

I am pleased to submit for your review the semi annual report for the period April 1, 2002 – September 30, 2002. This report reflects the activities of the Office of the Inspector General over this six-month reporting period. In addition to the summary of activities of the Office found in Chapter One, Chapter Two includes the findings and recommendation from reports completed within this time frame. Additionally, Chapter 3 outlines the recommendations made by the OIG that have not been resolved as of September 2002.

This office has been instrumental in stimulating a number of changes, which have increased the quality of care within the facilities operated by the Commonwealth of Virginia for individuals with serious mental illness and mental retardation. We are proud to be of service to this often disenfranchised and vulnerable group of citizens. It is a profound function of government to provide for those who are incapable of caring for themselves. As you will see from this report, the Office of the Inspector General provides a critical function by providing accountability regarding access to quality care for these citizens and their families.

Sincerely,

Anita Everett, M.D.
Inspector General

P.O. Box 1475 · Richmond, Virginia 23218 · (804) 692-0276 · FAX (804) 786-3400 · TTY (804) 786-7765

Executive Summary

In the period from 1991 to 2002, the Department of Justice (DOJ) found conditions of inadequate treatment and unsafe conditions in 5 of 15 Mental Health and Mental Retardation facilities operated by the Commonwealth of Virginia. The Office of Inspector General (OIG) was created to provide ongoing accountability to consumers as well as state officials regarding treatment and conditions within these state operated facilities. Accountability is provided through reports from unannounced inspections at each state facility. Reports are posted on the OIG website (www.oig.state.va.us) with the exception of those reports that contain confidential medical records or have met the strict definition of peer review.

This report has been prepared per §37.1-256.1 in the Code of Virginia, which requires the creation of a six-month report that summarizes the activity of the office as well as recommendations for corrective action and active findings, which have not been successfully resolved. Additionally, §37.1-257 requires the ongoing monitoring of critical events and participation in the development of regulations. §37.1-257 requires that the OIG conduct an unannounced inspection at each facility and that the following elements are commented on: general conditions, staffing patterns, and access to active treatment. These are based on the provisions of the Federal Civil Rights For Institutionalized Persons Act, which prevents the warehousing of mentally disabled persons in unsafe environments. Additionally, §37.1-256.1 allows for the reporting on significant problems and deficiencies in any program that is licensed by the Department of Mental Heath, Mental Retardation, and Substance Abuse Services (DMHMRSAS).

During this 6-month reporting period, the office completed twelve unannounced facility inspections. Eight were routine unannounced inspections and four were special inspections conducted in response to a possible concern in trends or concern about a specific incident at a facility. Approximately 485 critical incident reports were reviewed within this semi-annual period and an additional level of scrutiny was conducted for 147 of these incidents. The OIG has been working together with DMHMRSAS on the collection of facility data, which allows for the ability to monitor critical trends such as utilization of seclusion and restraint.

The OIG worked on several special projects within this reporting period. These included several legislative studies related to child mental health services in Virginia as well as a survey of access to nationally recognized evidence based best practice in community mental health settings in Virginia. Several Departmental Instructions were formally reviewed, and a number of public presentations were made.

Chapter One summarizes the activities of the office over the last six months. Chapter Two contains the text of the facility inspections that have been completed within this six-month period. Several of these reports indicate an ongoing dependency on overtime to provide safe staffing levels. This problem is compounded by the national nursing shortage. Chapter Three contains each of the currently outstanding findings and

recommendations that are being monitored by the OIG. Findings and corresponding plan of correction are reviewed periodically and are not made inactive until the circumstances as written in the facility plan of correction are met. In order to conserve resources, the full text of Chapter Two and Three are available on the OIG website (www.oig.state.va.us).

It is our intent that this report reflects the value and role of this Office in preventing further expensive litigation with the Federal Government and the DOJ. Several advocate representatives asserted in the legislative study of the OIG, that given the current status of the financial affairs of Virginia, now more than ever is the time to preserve independent and objective review of services. This report demonstrates that this small office has been extremely effective in identifying and monitoring a number of situations that represent risk to consumers. In addition we have worked to promote performance improvement throughout the publicly funded mental health, mental retardation and substance abuse system.

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CHAPTER 1 - ACCOMPLISHMENTS

The Office of the Inspector General (OIG) was established to increase accountability of the public funded Mental Health, Mental Retardation and Substance Abuse Services System in Virginia. In the period from 1991 to 2002, the Federal Department of Justice found conditions of inadequate access to active treatment and unsafe conditions in four Mental Health Hospitals and one Training Center (institutions for the mentally retarded). This represents 5 of 15 state operated institutions. The Office of Inspector General was created to provide ongoing accountability to consumers as well as elected officials regarding conditions within these state operated facilities. Accountability is created through unannounced inspections at each state facility. Reports from these inspections are posted on the OIG website. (Occasionally the circumstances of an individual consumer must be included in reports. In this case the reports are not released to the website.) Additionally each six months a report is provided regarding general conditions within facilities to the General Assembly.

The OIG is a very small office that was created to provide independent professional expert opinion regarding the status of state facilities in terms of access to care in a safe environment. This is a civil right of an institutionalized person. Specifically, as is required with the Virginia Code each year every facility is visited and reported on regarding three basic elements found to be inadequate by the Department Of Justice. These are: general conditions and safety, adequacy of staffing and access to adequate treatment.

This office is set up with the intention of inspiring performance improvement as opposed to strict compliance monitoring. The OIG starts with the assumption that most clinician-employees are motivated to provide good care that has a positive impact on the consumers they work with. Administrators who work within these facilities and systems of care are motivated to support clinicians in providing quality care.

This report outlines the work of the Office during the semi-annual reporting period April 1-September 30, 2002.

A. INSPECTIONS

According to the Virginia Code established through legislation from the 2001 General Assembly, the OIG is required to conduct at least one unannounced inspection at each of the fifteen state facilities operated Mental Health and Mental Retardation facilities annually. This legislation mandated that at a minimum the following elements are reviewed: the general conditions of the environment, adequate staffing and the availability of active treatment programs.

In order to assure that these conditions are met, the OIG routinely conducts unannounced visits during weekends, holidays and across shifts. This approach is unique and separates the office from other public and private monitoring and/or reviewing organizations, such as Joint Commission for the Accreditation of Healthcare Organizations.

During this reporting period, the office conducted four secondary and eight snapshot inspections.

Eight snapshot inspections were conducted within this six-month reporting period. A snapshot inspection is an unannounced, inspection wherein conditions, staffing and activity of patients are directly observed at a point in time. One snapshot inspection was conducted at each of the following facilities:

Central State Hospital in Petersburg;
Central Virginia Training Center in Lynchburg;
Hiram Davis Medical Center in Petersburg;
Northern Virginia Mental Health Institute in Fairfax;
Southside Virginia Training Center in Petersburg;
Southern Virginia Mental Health Institute in Danville;
Southwestern Virginia Mental Health Institute in Marion; and
Southwestern Virginia Training Center in Hillsville

Four secondary inspections were conducted based on specific concerns or complaints received by the office regarding issues associated with quality of care for consumers. Secondary inspections generally involve some form of peer review and may not be able to be released to the OIG website when to do so would breech individual confidentiality or the peer review process. Secondary inspections were completed at the following facilities in this six-month reporting period:

Northern Virginia Mental Health Institute in Falls Church
Catawba Hospital in Catawba
Southside Virginia Training Center in Petersburg
Western State Hospital in Staunton

B. REPORTS

Reports are the mechanism for communicating the findings and recommendations, which resulted from an inspection. Reports are forwarded to DMHMRSAS and then to the facility for the development of a plan of correction. A Plan of Correction (POC) addresses each recommendation and becomes the agreement between the OIG and DMHMRSAS by which progress is monitored during onsite follow-up visits. Once the POC has been finalized; the report, POC and OIG acceptance of the POC are forwarded as a complete report package to the Governor's Office.

During this semi-annual reporting period there were 11 completed inspections report packages.

These included:

Eastern State Hospital / Report #53-02
Southeastern Virginia Training Center / Report #54-02
Northern Virginia Training Center / Report #55-02
Commonwealth Center / Report #56-02
Western State Hospital / Report #57-02
Piedmont Geriatric Center / Report # 58-02
Catawba Hospital / Report #59-02
Southern Virginia Mental Health Institute / Report #60-02

Central Virginia Training Center / Report #61-02
Southside Virginia Training Center / Report #62-02
Northern Virginia Mental Health Institute / Report #64-02

Governor Warner's Office has been very timely in responding to reports as submitted and has granted release to the OIG website of every OIG report other than those which contain consumer specific information.

C. SPECIAL PROJECTS

The OIG worked on 10 special projects during this reporting period. Special projects are activities beyond the regular inspection reporting process. And are designed or accepted as a project if they enhance overall knowledge of the system and if they will be associated with opportunity to participate in a project that has direct impact on the quality of care to persons with mental disabilities in Virginia. The OIG initiated six of the special projects and four were associated with studies of the 2002 General Assembly.

The projects initiated within the OIG included:

Community Services Board (CSB)/Family Education and Illness Management Project – This project or program audit was designed to assess two areas, which have been demonstrated in multiple studies to be a vital component in the best practice treatment of those with serious and persistent mental illness in a community setting. These include: the availability of formalized education to families regarding mental illness, and formalized illness management education for consumers regarding the nature and outcome of their illness as well as anticipated impact a untreated mental illness can have. This project was designed as a simple survey regarding availability of programming in these two areas. Representatives from each of the forty CSB's were interviewed. This survey found that each of the CSB's offered some form of illness management and approximately three fourths offered some form of family education. Many of the areas that currently did not have a family education program had had one in the past but no longer maintained it. Recommendations for consideration included expansion of family education to all areas of the Commonwealth as well as consideration of further study of the composition of the illness management programming that in many cases in Virginia was developed locally in order to benchmark against national research supported programming in illness management.

Mortality Study – A second Mortality Study began in January 2002. This study focused on all deaths, which occurred in the facilities between November 1, 2000 – October 31, 2001. The purpose of the study is to review the clinical circumstances of each of these deaths. A retrospective chart review was completed on the 89 patients who died while admitted to a Virginia mental health or mental retardation facility during the twelve-month study period. This report is in draft form at the time of this six-month report and will be completed within the next several weeks. One simple piece of information is that the number of mortalities in this review, 89, is significantly less than during the one year period studied years two years ago at which time the number of deaths was 127.

Child and adolescent bed utilization – This report is a preliminary review of private and state-operated psychiatric bed utilization for children and adolescents in Virginia. This preliminary review was conducted due to the concerns and issues raised regarding the impact of the closure of several hospitals acute care units designed to provide treatment to children and adolescents.

Psychiatrists in Underserved Areas – The goal of this program is to encourage psychiatrists to pursue practice in a rural area in Virginia. This program is administered through joint participation of the Virginia Department of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Inspector General. The program provides support through loan repayment and interaction with medical school programs to encourage providers in training to pursue careers in these underserved areas in Virginia. Four psychiatrists have been placed in practice in rural areas in Virginia as of July 1, 2002 as a result of this program and a number more are on the immediate horizon.

American Association of Community Psychiatrists (AACP) Winter 2003 meeting. The Inspector General has invited the AACP to hold its annual Winter Meeting in Virginia. This two-day event will be held in Charlottesville on February 7 and 8. This meeting will bring together national and Virginia-based mental-healthcare professionals in a forum designed to promote information exchange on effective models for recovery in public funded mental health services.

Training Center Resource Inequity – In 2001, the OIG concluded a review of staffing patterns within all five Virginia training centers as it relates to quality of care. The data demonstrated that the residents in several training centers were at risk due to inadequate access to appropriate numbers and levels of staffing. Emergency funding was made available and maintained within the State Budget to alleviate these at risk conditions. A second training center resource study has been conducted. The preliminary findings are currently in draft form.

OIG involvement in studies associated with the 2002 General Assembly:

OIG Study - The2002 Appropriation Act directed the Secretary of Health and Human Resources, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Office of the Inspector General, the Office for Protection and Advocacy, and mental health advocates to examine the role and responsibilities of the Office of the Inspector General in the mental health system. Actions requiring statutory or appropriation revisions are to be recommended to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 31, 2002.

A committee, which was chaired by Secretary Woods, was convened for this purpose, this included representatives from thirteen organizations. Three meetings were held. These were designed to provide opportunities for the committee to learn, deliberate and report recommendations and findings to the Secretary.

CSA Project - The IG was invited to participate in a legislative study of the Comprehensive Services Act and served as the chair of the committee on monitoring and evaluation. The work of this group resulted in a 22-page document, which included the consensus of this work group regarding actions that could be taken immediately and long term. The central issue is the preservation of community or locality autonomy in providing services while providing sufficient accountability to state decision makers. The state has an interest in accountability regarding value and outcome.

SJR99 Committee - The IG was invited to participate with the Youth Commission in the development of a document on best practices for children with emotional disturbance. The IG participated on the steering committee as well as the clinical sub-committee of this process. This process met over the summer and created a document or resource for clinicians, educators, and families that is designed to provide general education regarding treatments that are supported by evidence as being beneficial for certain conditions.

Olmstead Committee - Governor Warner requested that a plan to monitor the implementation of the Supreme Court decision regarding Olmstead be developed in Virginia. In response to this, Secretary Jane Woods, together with the Virginia Office for Protection and Advocacy, as well as other agencies and organizations representing a wide variety of disabilities have developed a two year process which will result in an Olmsted Plan for Virginia. The Olmstead decision asserts that under the Americans with Disabilities Act (ADA), the unnecessary institutionalization of persons with mental disabilities constitutes discrimination under certain conditions. Dr. Everett has been invited to participate in the Accountability Monitoring work group.

D. DATA MONITORING

Critical Incident Reports

Critical incidents as defined by *§ 2.1-817* are sent to the OIG for review and monitoring. These incidents are those incidents occurring in one of the facilities that are serious enough to be associated with the resident or patient being evaluated by medical staff.

Approximately 485 critical incident (CI's) reports were reviewed within this semi-annual period of those within this semi-annual reporting period. The OIG completed additional scrutiny of 147 of the reviewed CI's, with additional inquiry requiring more information for 147 of these. This information is used to identify potential clinical problems with treatment of individuals within DMHMRSAS facilities and to track trends in facilities. The information is integrated into the inspections and schedule of the OIG.

Quantitative Data

In order to refine the inspection process so that core risks as identified by DOJ could be monitored, a monthly facility report was instituted in January 2002. This report provides raw data on trends within facilities that might indicate a need for further clarification and onsite attention. Areas that are monitored through this monthly report include census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect.

E. FOLLOW-UP REPORTING

Four hundred and sixty one (461) findings and recommendations of the more than 600 findings and recommendations made by the OIG reports as of September 30, 2002 have been successfully acted upon and completed. Compliance with the accepted Plan of Correction (POC) is monitored by OIG through periodic onsite follow up visits.

Follow-up inspections were conducted at 8 facilities during this reporting period. This covered a total of 12 reports and 45 findings and recommendations, which had previously been active or unresolved during prior follow-up reviews.

Follow-up site visits are the mechanism by which the OIG verifies on-site the progress of a facility toward the compliance with the POC. Follow-up inspections in general are unannounced in order to gain a realistic perspective of the facility's progress. At a follow-up inspection, any active recommendations from previous Inspection reports are reviewed. Evidence is required from at least two sources in order to recommend that the finding become inactive. The sources may include interviews with staff, patients, review of procedures, memoranda, medical records, meeting minutes, or other administrative and/or clinical documents.

F. REVIEW OF DEPARTMENT INSTRUCTIONS AND REGULATIONS

During this semi-annual reporting period a formal review has been completed of DMHMRSAS sets of regulations and DMHMRSAS Departmental Instructions. These included the following Departmental Instructions (DI's):

DI1001 – Guideline for Implantation of HIPPA
DI 1002 – Minimum Necessary Use, Disclosure and requests regarding individually identifiable health information
DI1003 – Confidentiality and security measures for protection of information
DI1004 – Notice of privacy practices, authorization, verbal agreements and permitted uses of information for treatment, payment and healthcare operations
DI1005 – Rights of Individuals receiving services relating to information use or disclosure
DI1006 – Complaints processed and rights of Individuals receiving services with regard to protected information
DI1007 – Workforce information and HIPPA Complaints process and sanctions
DI1008 – Business associate contracts
DI1009 – Permitted use and disclosure of individually identifiable health information to external legally authorized officials
DI514 – Outside Employment and acceptance of gift
DI520 – Administrative Leave for victims of natural or technological disasters
DI 521 - Return to Work/Worker's Compensation Management Program
DI 701 – Organization and Maintenance of the Clinical Record

The following Regulations were formally reviewed within this reporting period:

12 VAC 35-105-10 Regulations for licensing Providers of Mental Health Services

G. PRESENTATIONS AND CONFERENCES

During this reporting period presentations were provided for the following state and national groups and meetings associated with the mental health, mental retardation and substance abuse community:

American Association of Community Psychiatrists spring meeting
Virginia Alliance for the Mentally Ill annual conference
American Psychiatric Association
Virginia Rural Mental Health Resource Center Conference
SAARA Conference (Keynote speaker)

H. MEETINGS

The OIG regularly participates in a variety of forums that address issues relevant to DMHMRSAS facilities and mental health issues.

DMHMRSAS Facility Directors' Meeting;
DMHMRSAS Facility Medical Directors' Meeting;
Virginia Association of Community Psychiatrists;
American Psychiatric Association semi annual conference
DMHMRSAS Access and Alternatives process
Psychiatric Society of Virginia
Coordination with Virginia office of Protection and Advocacy

CHAPTER 2

Reports completed of Inspections conducted between April 1 – September 30, 2002

CATAWBA HOSPITAL
CATAWBA, VIRGINIA
JACK WOODS, DIRECTOR

OIG REPORT #59-02 - Secondary Inspections are conducted in response to a serious incident. The Inspections rely, in part, upon information provided by committees that reviewed, evaluated and made recommendations on the adequacy and quality of services provided. The Inspections include a review of precipitating factors and a clinical review of the acute management of the incident. In accordance with Virginia code, §8.01-581.16 – 17, these reports are not available for public release in order to protect the privacy of the patients referenced in this report concerning this incident and the privilege for peer review documents.

CENTRAL VIRGINIA TRAINING CENTER
LYNCHBURG, VIRGINIA
JUDY DUDLEY, DIRECTOR

OIG REPORT# 61-02

A Snapshot Inspection was conducted at Central Virginia Training Center in Lynchburg, Virginia during May 16, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and active treatment.

Overall, this facility was clean and well maintained. It was noted that staff have made efforts to make these outdated and institutional buildings appeared more homelike. The facility has established a mechanism for assessing and correcting environmental hazards, which has resulted in fewer resident injuries.

The staffing patterns established by the facility for coverage were met on each of the units toured during the inspection. Overtime was noted to be minimal.

Record reviews revealed that the facility provides for active treatment programs designed to meet the individualized needs of the residents. It was learned that the second psychiatrist hired by the facility had resigned resulting in one full-time psychiatrist providing care. It was reported that the segment of resident population requiring psychiatric treatment has been increasing over the past several years at CVTC, making the availability of this service more critical.

Finding 1.1: Overall, the facility was clean, odor-free and well maintained.

Background: During this inspection, tours were conducted in Buildings 2, 6, 7, 15, and the Shenandoah House. The units were noted to be clean, well maintained and odor-free. Bathrooms were observed to be clean. Hallways and rooms were not cluttered. Equipment and items appeared properly stored. Personal and decorative items were observed in each of the buildings toured. It was apparent that staff has made efforts in making these out-dated institutional buildings more home-like, such as with stenciling on the walls, plants and pictures. It was noted that the availability of personal decorative items varied among the units.

Recommendation: Maintain current attention to a clean and orderly environment that reduces institutional appearance to the extent possible.

Finding 1.2: The facility has established a mechanism for assessing and correcting environmental hazards.

Background: Each unit has been assigned a safety officer, who is responsible for daily monitoring of potential safety hazards. This person reports any identified problems to Buildings and Grounds. Building and Grounds prioritizes these work requests and completes the work as soon as possible. Interviews and observation during the facility tour demonstrated that the facility has institutionalized this integrated model for the ongoing assessment and correction of environmental safety hazards. Persons from a variety of disciplines are involved at least on a monthly basis in meetings that review identified potential risks and then developing strategies for correcting these problem areas. This process has included: the replacement of all old and hazardous furniture with cushioned, easier to clean furniture; the removal of all unused furniture; the removal of all obstacles in bathrooms, bedrooms and dayrooms; the inclusion of castors under beds; the use of less shine floor wax; inclusion of shower mats on slick areas; and the repair of cracked sidewalks and walk ways.

Recommendation: Sustain the current system for evaluating and correcting potential risk factors. It is recommended that opportunities be made available for CVTC to share this model with other facilities.

DMHMRSAS Response: DMHMRSAS concurs. We appreciate that the Inspector General recognizes the strides that the facility has made in assessing and correcting environmental hazards. CVTC's safety officers continue their monitoring, and the Facility's Event Review Committee continues to meet on a monthly basis to review identified potential risks and develop strategies to address these risks. Additionally, the Risk Manager, Safety Director and Director of Buildings and Grounds work collaboratively with center staff to reduce risk factors. CVTC will ensure that these activities continue.

Finding 2.1: Staffing patterns met the facility expectations during the inspection.

Background: Interviews and observations demonstrated that the expected number staff were available.

Staffing patterns were as follows:

Unit 2A - 8 residents and 2 DSA's; (2 med aides and 2 supervisors for Building 2)
Unit 2B - 13 residents and 4 DSA's; (2 med aides and 2 supervisors for Building 2)
Unit 2C- 10 residents and 2 DSA's; (2 med aides and 2 supervisors for Building 2)
Unit 2D- 6 residents and 2 DSA's; (2 med aides and 2 supervisors for Building 2)
Unit 7A- 13 residents and 5 DSA's; 1 Activities Therapist for 7 A and 7B
Unit 7B - 14residents and 4 DSA's;
Unit 15B - 15 residents and 3 DSA's

Out of 27 staff two staff were working overtime.

CVTC is aware of specific staffing concerns and continue to take steps to address the shortage of staff due to the high level of staff entering retirement. Given the nature and complexity of current residents, 1:5 staff to resident ration as was witnessed in several units is minimal.

Recommendation: Maintain current efforts to sustain facility staffing expectations.

DMHRSAS Response: DMHMRSAS concurs. CVTC has implemented a centralized interview process in an effort to improve the timeliness of interviews and to generate a continuous flow of new interviewees and employees.

Finding 2.2: There is insufficient psychiatric coverage to meet the needs of residents at CVTC.

Background: Interviews reveal that CVTC had received notice that the contract psychiatrist resigned effective the end of May 2002, due to a family relocation. This results in the facility having only one full-time psychiatrist. Record reviews demonstrated that 3 of 5 records did not have documentation of psychiatric follow-up for prescribed interventions. It was reported that the segment of resident population requiring psychiatric treatment has been increasing over the past several years at CVTC, making the availability of this service more critical.

Recommendation: Prioritize the recruitment of additional psychiatric services at CVTC.

DMHMRSAS Response: DMHMRSAS concurs. CVTC continues the recruitment for additional psychiatric services. The Facility Director has also spoken with the Director of Catawba Hospital to determine the possibility of obtaining additional or shared psychiatric resources from Catawba Hospital.

Finding 2.3: This facility has committed resources to enhance staff training and career advancement.

Background: Interviews with administration staff and line staff indicated that CVTC has created an atmosphere that provides the opportunity for staff at all professional levels to engage in comprehensive staff training and or career advancement training. Four line staff were interviewed and provided examples of co-workers that had been financially supported through reimbursement to advance their career through higher education.

CVTC has dedicated $778,340 in FY 2002 and $743,340 in FY 2003 for Advanced Career Training and Staff Development for all facility staff. In FY2002, educational assistance has been provided to 36 employees. Ongoing inservices for all staff.

Recommendation: Maintain the commitment to provide career advancement training and professional development to all staff.

Finding 3.1: CVTC has developed active treatment to meet individual resident needs.

Background: Five record reviews and observations indicated that the facility has integrated active treatment into the daily routine. This enables clients to receive individualized program and levels of supervision commensurate with their needs. Interviews with a variety of disciplines demonstrated that staff work together to create a team approach to offer the most appropriate level of active treatment.

Recommendation: Continue to develop active treatment the meets individual resident needs.

DMHMRSAS Response: DMHMRSAS concurs. CVTC continues to develop active treatment that meets the needs of the clients and to provide training to staff in the area of active treatment. In April of this year, facility Charge Aides were trained in active treatment by a Ph.D. psychologist.

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
FALLS CHURCH, VIRGINIA
MOHAMMAD EL-SABAAWI, DIRECTOR

OIG REPORT # 64-02 - Secondary Inspections are conducted in response to a serious incident. The Inspections rely, in part, upon information provided by committees that reviewed, evaluated and made recommendations on the adequacy and quality of services provided. The Inspections include a review of precipitating factors and a clinical review of the acute management of the incident. In accordance with Virginia code, §8.01-581.16 – 17, these reports are not available for public release in order to protect the privacy of the patients referenced in this report concerning this incident and the privilege for peer review documents.

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
DANVILLE, VIRGINIA

OIG REPORT # 60-02

A Snapshot Inspection was conducted at the Southern Virginia Mental Health Institute in Danville, Virginia during May 6 - 7, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and the activity of patients.

Overall, the facility was clean and well maintained. Recent renovations changed the placement of the nurses' station, which has resulted in increased opportunities for interactions between the staff and patients. Patients related feeling both safe and comfortable within the facility.

Staffing patterns were noted to meet the expectations outline by policy and procedures for this facility. Nursing staff were identified by the patients as most the staff members most significant in their recovery process.

The facility provides individualized treatment planning. There was evidence that the patients were provided with multiple opportunities to participate in the development of treatment and discharge planning.

Finding 1.1: The facility was clean, comfortable and well maintained.

Background: Tours were completed of the facility during the evening shift of May 6, 2002. The facility is divided into four units, which serve 18 patients each, with a census of 72. Overall, the facility was noted to be clean, comfortable and well maintained. SVMHI has completed several environmental updates, including the completion of an asbestos abatement project. The project resulted in the environment being updated, appearing less institutional. SVMHI has created a more home-like environment through the use of photographs, patient artwork and other pictures, and through the creation of different groupings of furniture, which allows for increased interaction and affords increased privacy in conversation during visits.

The nurses' station was renovated during the floor tile replacement project. The previously large half-circle desk located in the dayroom area was removed expanding the available dayroom space. The current nurses' stations are located about mid-way down each residential unit's hallway. Interviews with both nursing staff and patients revealed that this arrangement has allowed for increased opportunities for interaction between the staff and patients.

All of the ten patients interviewed indicated that they felt safe and comfortable in the environment. They indicated that they were allowed to display personal items and encouraged to create artwork for display within the facility.

Recommendation: Maintain this environment while continuing to explore additional ways of updating this environment.

Finding 2.1: Staffing patterns were consistent with defined facility expectations for evening coverage.

Background: There was at least one RN for each unit during the time of the inspection. There was also a nurse shift administrator Staffing patterns were as follows:

E Unit	1 RN	2 HCSWs	for	16 patients
F Unit	2 RNs	2 HSCWs	for	20 patients
G Unit	2RN	3 HSCWs	for	19 patients
H Unit	1 RNs	2 HSCWs	for	19 patients

Recommendation: Continue to maintain staffing patterns for providing adequate coverage.

DMHMRSAS Response: DMHMRSAS concurs and appreciates recognition of SVMHI's staffing patterns for evening coverage. SVMHI is committed to maintaining appropriate staffing levels, despite a challenging job market.

Finding 2.2: Patients identified the nursing staff as having the most significant impact on their recovery process.

Background: Ten patients were interviewed during the inspection. All indicated that nursing staff were the most helpful in their recovery process. They related that the nursing staff took the time to talk with them, address concerns and found ways to assist them in everything from maintaining their clothes to understanding their medications.

The inspection took place during nurses' appreciation week. None of the staff were aware of any activities planned for the week, which were designed to recognize these hard-working individuals. Administrative staff were also unable to identify any planned activities, but spoke of events that had occurred during previous nurses' appreciation week.

Recommendation: With identified concerns regarding the use of overtime and recruitment and retention problems state wide for nursing staff, this facility needs to formally recognize the efforts of this group of workers identified as the most helpful by patients.

DMHMRSAS Response: DMHMRSAS is pleased with the OIG finding that patients view the SVMHI nursing staff as significant to the recovery process. SVMHI is aware of the valuable contribution of its nursing staff, and makes regular efforts to acknowledge its nurses. Annually, SVMHI recognizes Nurses' Week both at the facility level and the unit level, but at the time of the OIG's visit, arrangements had not been finalized. The facility also makes every effort to recognize the individual efforts of the nursing staff on a case-by-case basis throughout the year.

Finding 2.3: SVMHI is reducing funding for staff training for FY 2003.

Background: OIG inspection team interviews with administrative and direct care staff indicated that in FY2002, the facility had committed funding for career advancement and professional training that created an environment of opportunity. All direct care staff commented that they were trained in the facility with a constant offering of inservices that were applicable to the patients they were responsible for treating. In addition they relayed that they knew many or had themselves been able to participate in off campus educational experiences. In the past, the facility had been able to dedicate approximately $13,000 for travel to professional conferences and professional educational stipends. An additional five thousand dollars was used to bring in professional experts.

The facility has reported that for FY 2003, budget reductions will prohibit SVMHI from dedicating any funding for travel and stipend funding. This will not affect the in services that are provided internally rather it will discontinue funding for professional conferences and professional educational stipends.

Recommendation: Work with the Central Office to formulate availability to continue career advancement education for professional and direct care staff.

DMHMRSAS Response: DMHMRSAS concurs. The Central Office of Human Resource Development will work with SVMHI to explore creative ways of continuing career advancement education for professional and direct care staff, to include shared training efforts with other facilities.

Finding 3.1: Evening active treatment and leisure activities were available for patients.

Background: SVMHI provides for a variety of active treatment programs for the patients. The inspection team was onsite during a Monday evening second shift. Interviews and observations revealed that a variety of activities were available. A socialization group was occurring at the time of the tour. A number of patients were participating in an evening recreational activity in the gym. Visiting hours were also occurring and several patients were engaged in conversation with family members. Several clusters of patients were engaged in structured card games.

Recommendation: Continue to develop programming choices for patients that addresses individual needs.

DMHMRSAS Response: DMHMRSAS concurs and appreciates recognition of the evening programs provided to SVMHI patients. SVMHI, through its Psycho-social Rehabilitation Committee, will continue to develop programming choices that address individual needs. To better assist identification of patterns of patient need, SVMHI recently adopted a modified version of the computerized scheduling and attendance program used at a sister facility. This program will help clinical decisions regarding the expansion or reduction of specific groups or activities.

Finding 3.2: Treatment planning is individualized and designed to meet the patients' treatment needs.

Background: Interviews were conducted with ten patients during this inspection. All of the patients were able to identify treatment goals and barriers to their discharge. Each spoke of the many opportunities they have had to participate in the development in their treatment and discharge planning. Eight out of the ten were able to identify their medications and its purpose. One patient indicated that it was his belief that SVMHI had actually saved his life. He spoke of his twenty year battle with his mental illness and indicated that having the option to enter this facility when his "grasp on reality was fragile" enabled him to get the assistance he needed to remain a productive citizen.

Recommendation: Continue to actively involve the patients in their treatment planning process.

DMHMRSAS Response: DMHMRSAS concurs and appreciates recognition of SVMHI's clinical accomplishment regarding individualized treatment planning. SVMHI is committed to continuing involvement of patients in the treatment planning process.

Finding 3.3: SVMHI has closed the token store.

Background: Patients interviewed indicated that they were upset when the facility decided to close the token store due to budget reductions. Administrative staff related that the decision was discussed with the patients. The facility will consider reopening the token store if funding becomes available.

Recommendation: None.

DMHMRSAS Response: None.

SOUTHSIDE VIRGINIA TRAINING CENTER
PETERSBURG, VIRGINIA
JOHN HOLLAND, DIRECTOR

OIG REPORT #62-02

A Snapshot Inspection was conducted at Southside Virginia Training Center on June 11-12, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and active treatment.

A tour of eleven duplex cottages on the facility's campus revealed that overall, the units were clean, comfortable and well maintained. Staff efforts to make the environment homelike were evident throughout the tour.

Given the complexity of the residents served within this facility, the number of staff present was minimal. Staffing patterns did exceed the minimum numbers as established by SVTC. The inspection team was informed that the numbers of staff present the night of the inspection was not representative of the recent past. Recent staff shortages have resulted in low staff to patient ratios over the last several weeks.

Evening activities were evident. Active treatment programs were reviewed in the areas of prevocational, pre-community living and community living training.

The facility has been working on establishing a cooperative relationship with the local community college to provide enhanced career opportunities for the staff through grant application for federal funds to provide on-site classroom training opportunities, a child development center and after school program.

Finding 1.1: Overall, the cottages inspected at this facility were clean, odor-free and well maintained.

Background: During the inspection a tour was completed in 11 cottages consisting of 22 units. Overall, the facility was clean, odor free and well maintained. Each unit was decorated, creating a homelike atmosphere. This included: borders, pictures; entertainment centers; faux and real plants; built-in book shelves; dining room furniture, tablecloths and placemats. The tour reveled that each unit had a neat, tidy appearance throughout all living areas.

Recommendation: Maintain current attention to a clean and orderly environment that reduces institutional appearance to the extent possible.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates recognition by the Inspector General of this facility's efforts. SVTC will continue to maintain a clean and orderly environment and to reduce the institutional appearance of the living areas. Towards this goal, SVTC has engaged in these activities, among others:

- 90% of Living area space in Building #125 has been painted;
- Decorative borders have been added in several bedrooms, dayrooms, dining rooms and lobbies;
- Flowers and greenery have been installed in many outside areas.

Finding 1.2: The facility grounds were nicely landscaped.

Background: During the tour, the inspection team observed that the facility has given considerable attention to beautifying the campus. This was accomplished through numerous shrubberies, flowers and generally well-maintained grounds. This represents significant improvement in these grounds. This campus gave the impression of a community based apartment complex.

Recommendation: Sustain the current beautification efforts.

DMHMRSAS Response: DMHMRSAS concurs, and appreciates recognition by the Inspector General of the facility's landscaping. SVTC will continue efforts to enhance the attractiveness of facility grounds. Examples of SVTC efforts include: Service drives in the cottage area curbed, side walks curbed and edged, grass fertilized and limed, outside of buildings painted as required, shrubs and trees trimmed and pruned, service drives paved and/or patched as required, and wood rail fences repaired as required.

Finding 2.1: Staffing patterns were consistent with the prescribed facility standards.

Background: Interviews and observations demonstrated that the expected number of staff were available. All units visited had a staffing ratio of 2:8, except for Unit 30 in which one staff member was off the unit on break; Unit 31 had a 3:8 ratio; Unit 19 had a 1:8 ratio due to the second staff member being off campus for personal reasons; and Unit 28 had a ration of 3:10.

During interviews staff indicated that this was a full compliment of coverage, which was unusual due to recent staff shortages. One staff member indicated that there had been 11 separations from service on the evening shift in the past few months and nine on the night shift. During this inspection only one person reported working overtime during the shift.

Recommendation: Maintain current efforts to sustain facility staffing expectations.

DMHMRSAS Response: DMHMRSAS concurs. Like other state and private facilities, SVTC continues to be challenged by difficulty recruiting and retaining direct care and nursing staff.

SVTC has joined with the other two facilities on the Southside Campus (Central State Hospital and Hiram W. Davis Medical Center) in a collaborative effort to recruit, hire and retain direct

care and nursing staff through a dynamic workforce development plan. SVTC's Workforce Development Director has worked with a campus-wide committee on the development of a Workforce Fair. The Governor has designated the Southside Campus as a Commonwealth of Virginia Workforce Development Demonstration and Pilot site.

Workforce Development Day was held May 21, 2002. The purposes of the fair included: providing both present employees and members of the community information about careers here; providing time for people from the community to complete job applications; to assess interest, providing information about educational opportunities that we hope to provide in the future (e.g., GED, workforce training, college classes held on this campus); and, allowing our community partners (e.g., community college, VEC) to be here in contact with our employees and people from the community.

All the facilities were pleased with the excellent turnout. The outcome information is still being analyzed to determine the next steps in our workforce development. At SVTC, a class of newly-hired staff, which includes 34 Direct Service Associates, began July 25, 2002.

Finding 2.2: There was significant variability among staff in ability to define examples of abuse and neglect.

Background: Out of ten staff interviewed five could not articulate working definitions of abuse and neglect. This represents a significant number of persons who would have difficulty maintaining the "watchful eye" necessary to actively prevent abuse and neglect from occurring. Without having a clear professional definition of abuse and neglect, staff may call upon their own personal ideas and experiences regarding discipline or behavior modification. Four out of the five staff that had difficulty relaying examples had less than five years of experience, one out of the five had almost thirty years but did not believe that abuse could occur to wheelchair bound residents, only incidents of neglect. Each staff relayed that they had received or would receive abuse and neglect training on an annual basis.

Recommendation: Consider conducting a competency evaluation of staff knowledge regarding abuse and neglect and conduct retraining as necessary.

DMHMRSAS Response: DMHMRSAS concurs. During unit rounds, facility administrators currently utilize competency probes regarding the new Department Human Rights Regulations and the Abuse/Neglect Investigation process in order to assess the overall knowledge of SVTC direct service staff. To enhance the value of this performance measure, SVTC will provide its administrators with additional training on conducting competency probes, and will increase the frequency of reviews of relevant data by administrators. In addition, SVTC will incorporate 'real-life' scenarios on abuse and neglect as well as emphasize the definitions of various types of abuse and neglect into the on-going training processes for staff. Ninety-two percent of residential staff have completed training in the new Human Rights Regulations. Target date for 100% completion of that training is 9/18/02.

Finding 2.3: SVTC is developing a plan for becoming a workforce development pilot project site.

Background: The facility has been working on establishing a cooperative relationship with the local community college to provide enhanced career opportunities for the staff through a grant application for federal funds to provide on-site classroom training opportunities, a child development center and after school program. A survey of need was conducted with staff The survey noted that 30 individuals expressed an interest in pursuing nursing classes, 90 for classes in information technology, and 31 in allied health care professions such as physical therapy. Supportive service needs such a child or elder care needs were explored and addressed as ways of addressing potential barriers to staff members being able to successfully attend classes.

Recommendation: Maintain this commitment to provide career advancement training and professional development to all staff.

DMHMRSAS Response: DMHMRSAS concurs. Please see the response to Finding 2.1 regarding SVTC's efforts. SVTC also has applied for grant funding which will further support staff recruitment and development.

Finding 3.1: SVTC provides a variety of active treatment for residents.

Background: The inspection team toured and observed active treatment that served 250 residents of the 405 total facility population. The facility begins to transport residents to their designated active treatment program at 8:15am; this is completed by 9:45am. Active treatment is offered in varying segments from 9:00am -2:30pm. The inspection team observed active treatment that included, pre-vocational training; pre-community living training; and community living training. Each segment of active treatment was developed specifically to the individual needs of each resident. For example, two classes were comprised of visually impaired residents and the active treatment focused on environmental manipulation and included visual stimulation room. The inspection staff observed that the staffing patterns were consistent with facility expectations and because most residents remain within the educational building, the staffing included a nurse, Physical, Occupational and Speech therapy and nutritional management services located on site.

Recommendation: Continue to offer active treatment that has been developed to match each resident's varying developmental needs.

DMHMRSAS Response: DMHMRSAS concurs. SVTC will continue to provide and improve upon an intensive day habilitation program. Facility initiatives are planned for FY 2003 to further focus on individualized and person-centered services. The SVTC evening shift program system will be revised to provide services focused on nutritional management, physical management and leisure/recreation. Also, the data collection system for day services will be revised to increase focus on client-selected outcomes.

Chapter 3

Active Findings and Recommendations

This chapter contains findings and recommendations made by the OIG that had not been resolved as of September 30, 2002.

CATAWBA HOSPITAL
SNAPSHOT INSPECTION - JULY 10, 2000
OIG REPORT # 26-00

Finding 2.3: Record review did not reflect the treatment as verbally described by the staff interviewed.

Recommendation: Revisit with staff the process of documenting so that the chart reflects current treatment.

DMHMRSAS Response: Concur. The Facility Clinical Director and Chief of Staff have begun training all treatment teams in the importance of documenting in patient charts appropriately, accurately and in a timely fashion. Treatment plans are reviewed according to policy (i.e., every 7 days, every 14 days, and every 30 days as indicated) for priority needs and include a discussion of resolved issues. Discrepancies will be resolved as teams review diagnoses, treatment plans and discharge plans at each meeting. This will ensure the record reflects the most current plan of treatment.

In addition, the treatment planning policy for documentation relative to the treatment plans (Catawba Hospital Policy and Procedure 20.01) has been distributed. The Chief of Staff has directed the head of each treatment teams to act upon the policy and training, immediately.

The head of each treatment team will review the records monthly to ensure that the treatment plans and all documentation is accurate and consistent with the client's needs and treatment decisions.

6 Month Status Report: 7/1/01
There were no recommendations regarding treatment plans at the time of the 2000 JCAHO and Medicare surveys. A Treatment Plan Workgroup is working on the development of an automated treatment planning system. Once implemented, this should improve the accuracy and quality. Treatment Plans more accurately reflect the provision of treatment. Training of staff in the new system will include documentation requirements. Refer to June, 1999 report # 3.3 Documentation training is provided to clinical staff during new employee orientation. Monthly chart reviews are performed on a sample of records to ensure compliance

with documentation requirements.

OIG Comment - *During the June 2001 visit, record reviews demonstrated some improvements in the treatment plans. A performance improvement team has been working on this process and expects to implement a new, automated system within the next quarter. This finding remains* ***ACTIVE.***

6 Month Status Report: 01/01/02

During the past six months, Catawba Hospital staff have been involved with, and provided leadership for, specific areas of the DMHMRSAS system-wide project on the development or acquisition of a computer based treatment-planning program, which would be utilized throughout the facilities, and ultimately would be part of an automated medical record. This is an ongoing workgroup, which is continuing to review and evaluate existing treatment planning systems.

Catawba Hospital's Treatment Plan Workgroup has concurrently continued working on the development and operationalization of a computer-based treatment planning program that would address all of the requirements of the Departmental Instruction on Treatment and Habilitation Planning while incorporating the practical information and applications often generated by the Treatment Teams. During the next six months, Catawba Hospital plans to finish development of this software and begin testing prior to potential full implementation.

OIG Comment- *Interviews and record reviews revealed that this facility continues in its efforts to revise the treatment plans. As noted, the automated process is not completed at this time. This finding remains ACTIVE.*

6 Month Status Report: 07/01/02

Catawba Hospital staff continue to be involved in the DMHMRSAS project involving the development or adaptation of a computer-based treatment planning system as an ultimate part of an automated medical record. This part of the project is ongoing at this time and is being developed in the Central Office of Health and Quality Care.

The software has been developed for Catawba Hospital's computer-based automated treatment plan. At this time, the workgroup is in the process of finishing the content of this plan which involves the definition of problem areas and associated objectives and interventions. We have been recently working toward improving Treatment Plans for high-risk events, including aggression and falls. The content involving aggression has been added to our existing computer-based treatment planning program. The content involving falls should be added to the program within the next six weeks. Both of these will also be utilized in the new treatment plan structure. The facility plan on piloting and refining and, if successful, utilizing the new treatment planning program within the next six months.

CENTRAL STATE HOSPITAL
RESPONSE TO SNAPSHOT INSPECTION, JULY 17, 2000
OIG REPORT # 29-00

Finding 3.4: Staff relates that the use of mandatory overtime for Human Service Care Workers (psych tech) had increased recently.

Recommendation: Please forward the current assessment of and plan for the psych tech overtime situation in building 39 at CSH. If there is not a current working plan, please forward the date by which one will be completed.

DMHMRSAS Response: See above plan, "CSH Action Plan for Direct Staffing" (Response to Finding 3.3).

6 Month Status Report: 7/1/01
The FMHT overtime hours during the IG visit in July 2000 were extraordinarily high at approximately 7200 hours for that month. The number of FMHT overtime hours have decreased to the point that during the most recent quarter, the monthly hours have averaged approximately 2600 hours. The Nursing Department developed a specific deployment plan to ensure that consistent coverage across the wards and across the days of the week. In addition, a number of the vacant FMHT positions have been filled. Overtime continues to be monitored for patterns and trends by job categories (MHT, FMHT, SST). Identified problems will be immediately referred to Nursing for correction/ improvement.

OIG Comment - The administration has been attending to issues related to overtime hours and have developed a system to track and reduce mandatory hours. This finding is ***ACTIVE.***

6 Month Status Report: 01/01/02
We continue to monitor overtime usage on the wards and during the most recent 3 month period, the monthly overtime hours have averaged approximately 2600. This remains substantially below the approximately 7200 hours during the month of July 2000 when the Inspector General visited. The hours of overtime have leveled off , with forensic usage remaining higher than that of the civil wards. In an effort to address the forensic overtime hours, additional P-3 and P-14 FMHTs have been hired. Much of the overtime usage remains tied to one-to-one coverage for special precautions and suicide precautions necessary for patient safety. Nursing Management and the Medical Staff continue to monitor the use of 1:1 staffing for necessity and appropriateness. Efforts to minimize mandatory overtime have been active by using voluntary and P-14 before utilizing mandatory overtime. Mandatory

overtime is used only in situations where other efforts to provide coverage have failed. In an effort to ensure safety of our clients, voluntary overtime has been limited to 16 hours per pay period per employee.

OIG Comment *– Interviews indicated that the use of mandatory overtime has declined within the past quarter. The facility has instituted a process to monitor overtime that reflects a direct management priority in which the Assistant Directors of Nursing review the overtime shifts on a daily basis to address and justify the number of overtime hours worked. The facility continues to put effort into the recruitment and retention of DSA and nursing staff. The facility has a recruitment and retention committee, which is exploring the possibility of creating a campus wide daycare program onsite as well as providing educational courses on campus, bringing the classroom to the staff so that opportunities for enhancing knowledge and skills are more readily available. The facility has made great progress on addressing this issue, but because of the new ideas in addressing this issue and the historic tenure of this issue, the OIG will continue to follow the facility's progress. This finding is* ***ACTIVE.***

6 Month Status Report: 7/1/02

Overtime use continues to be monitored for necessity and appropriateness by Nursing Management and the Medical Staff. The number of hours in December 2001 was extremely high due to all the holiday coverage that had to be provided. While it has come down from that high level, it continues to be somewhat high due to 1:1 coverage for special precautions and suicide precautions deemed necessary for patient safety. There have also been a number of special hospitalizations outside of Hiram W. Davis Medical Center that require round-the-clock coverage. We continue to minimize the use of *mandatory* overtime, using P-14 coverage and voluntary overtime as much as possible.

SVTC's Workforce Development Director is working with the three facilities on the Southside Campus on a dynamic workforce development plan. She worked with a committee on the development of a Workforce Fair. Workforce Development Day was held May 21, 2002. (Please see ATTACHMENT A.) The purpose of the fair included: giving both present employees and members of the community information about careers here; providing time for people from the community to complete job applications; providing information about educational opportunities we hope to provide in the future (GED, workforce training, college classes held on this campus) to assess interest; and, allowing our community partners (community college, VEC) to be here in contact with our employees and people from the community. All the facilities were pleased with the excellent turnout. The outcome information is still being analyzed to determine the next steps in our workforce development.

CENTRAL VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
JULY 11-13, 2000
OIG REPORT # 27-00

Finding 5.3: Access to psychiatric services for residents outside the unit where the psychiatrist is housed may be compromised due to only one psychiatrist being available for the entire facility.

Recommendation: Consider mechanisms for increasing access to the psychiatrist such that every resident currently on or in need of psychoactive medication have access to a psychiatrist a minimum of one face-to-face visit every three months.

DMHMRSAS Response: In 1991, CVTC, in order to increase access to psychiatric services for clients, entered into an agreement with Western State Hospital (WSH) for services from one of their psychiatrists. As a result of this agreement, the WSH psychiatrist spends one day every other month at CVTC to evaluate and treat clients. CVTC is initiating steps to create a second full time psychiatrist on staff. CVTC now is reviewing documentation requirements and service processes in an effort to streamline the paperwork and increase client contact time by the psychiatrist.

5.3 6 Month Status Report 7/01/01:
CVTC created and advertised for a second psychiatrist; and at least four individuals called to make inquiries. However, as of this date, no applications have been received. There is one individual who recently indicated interest in the position and has asked for an application. The facility is hopeful. CVTC's psychiatrist met with the Medical Director at Southside Virginia Training Center (SSVTC) on April 12, 2001 to discuss and review both documentation efforts and service processes to help determine how CVTC might streamline its document-ation efforts. In addition, Dr. Jeffrey Geller, DMHMRSAS consultant, conducted a site visit at CVTC on June 28 – 29, 2001, during which he met with the facility's psychiatrist and Medical Director. He made suggestions on how to improve the service process and documentation efforts. CVTC's psychiatrist and Medical Director, after reviewing the information obtained from Dr. Geller and from SSVTC, will develop plans to move to a more effective treatment and documentation model.

OIG Comment– Interviews revealed that the facility continues in its efforts to increase psychiatric time. The contract involvement of a psychiatrist from WSH has been discontinued due to time limitations of that individual. The facility has approached several local psychiatrists in an effort to replace the one day a month availability provided by that contractor but has been unsuccessful in recruiting a candidate. Some discussion occurred with several other facilities regarding the possibility of sharing psychiatric coverage but this was not successfully completed.

The facility continues to operate with one full-time psychiatrist. It was noted on the date of this inspection that approximately 40% of the residents are prescribed psychotropic medications. This finding is ACTIVE.

5.3 6 Month Status Report 01/01/02:
CVTC has not been successful in recruiting for a second psychiatrist. To date, only one application has been received. A psychiatrist was interviewed, but the interview panel did not recommend the applicant for hire. CVTC has been discussing the possibility of contracting with a local psychiatrist to provide services one day a month to the facility.

OIG Comment – Interviews with administrative staff indicated that the second psychiatrist that had been hired by the facility resigned due to relocation. The facility plans to advertise in an effort to replace this individual. Interviews with a variety of disciplines and a review of records for behaviorally challenged individuals demonstrates that this facility's need for increased psychiatry time is critical. There are increased numbers of residents with dual diagnoses and complicated medication regimens. Three out of five of the records reviewed did not reflect that there was systematic method for assuring that appropriate follow-up occurs after intervention. This finding is ACTIVE.

5.3. 6 Month Status Report 07/01/02:
CVTC continues the recruitment for additional psychiatric services. The Facility Director has also spoken with the Director of Catawba Hospital to determine the possibility of obtaining additional psychiatric services from Catawba Hospital. Facility staff have also spoken with a retired psychiatrist from Roanoke who has indicated an interest in working for the facility on a part time basis.

Finding 8.2: Recent admissions have been more behaviorally and psychiatrically complex than in the past.

Recommendation: Residents transitioning into the community would benefit from the development of a Community Outreach Consultation Team to aid in treatment planning and implementation. This team, comprised of professionals from various CVTC disciplines, could assist community staff in the use of Applied Behavior Analysis for the development and monitoring of behavioral interventions.

DMHMRSAS Response: For mental retardation services, as well as mental health, rural communities have more difficulty obtaining and keeping staff with specialized expertise. While there are many factors contributing to this situation, a major factor is the strong economy, which creates strong competition from urban areas and from the private sector.

Applied Behavior Analysis (ABA) is a highly specialized area that has been adopted nationwide only recently. Here in Virginia, the Department began an ABA training program for facility staff just last year in collaboration with a contract with George Mason University. In FY 2002, the

Department will offer this training to CSB personnel; and, although space in the course is limited, the Department can give priority to staff from rural areas.

We understand that some CVTC staff have specialized skills that either have not yet been developed, or are available only on a limited basis, in community settings. At this time we do not feel that the development of a formalized team at CVTC is necessary. However, training center staff cannot maintain a professional treating relationship with individuals once discharged from the facility. The Department continues to encourage consultation by facility staff with community providers upon request for clients discharged from our training centers. Each training center is responsible for making the availability of such consultation known both to CSBs and to other community providers. CVTC, as in the past, will continue to make staff expertise available to communities serving clients who have been discharged in order to facilitate successful, long-term community placements.

8.2 6 Month Status Report 7/01/01:
CVTC continues to aid CSB case managers and providers in the transition planning to ensure successful placements for individuals. CVTC psychologists have provided consultation to CSBs as requested, and recently the facility's psychiatrist provided consultation to an MH facility regarding a client's treatment.

OIG Comments – Interviews indicated that the admissions to the facility continue to be very complex and challenging. The facility plans on enhancing behavioral management plans with the completion of the psychologist training and the recent hire of the PhD psychologists. This finding remains ACTIVE.

8.2 6 Month Status Report 1/01/02:
CVTC continues to aid CSB case managers and providers in the transition planning to ensure successful placements for individuals. CVTC psychologists and staff have provided consultation to CSBs as requested regarding clients who have been discharged from CVTC. CVTC is frequently the first point of contact for increasingly complex cases. CVTC staff often are able to divert admissions because of their familiarity with the state-wide array of services and are able to suggest more viable/appropriate options for individuals.

OIG Comment – Interviews with administrative staff indicated that the facility continues to receive referrals for challenging and often complex individuals. It was noted that the facility has recently received a number of admission request for individuals who were acknowledged as challenging for the community but did not meet admission criteria. It was commented upon that this facility ranks in the top ten in the nation for having the highest census. Census reduction efforts alone will not serve to provide a reasonable method for assisting this facility in coming in line with the other facilities. It is recommended that the Central Office evaluate the distribution and placement of MR residents within the DMHMRSAS resource system. This finding is ACTIVE.

8.2 6 Month Status Report 07/01/02:
CVTC continues to aid CSB case managers and providers in the transition planning to ensure successful placements for individuals. CVTC psychologists and staff continue to provide consultation to CSBs as requested, regarding clients who have been discharged from CVTC. CVTC psychologists successfully completed the Applied Behavior Analysis (ABA) training program developed by the Department in collaboration with a contract from George Mason University, and three CVTC psychologists recently passed the National Behavior Analyst Certification Examination. CVTC is providing videos of the ABA training to additional staff members (i.e. center management staff, I.D. Team Chairpersons, and QMRPs). Central Office through the Division of Facility Management has convened a workgroup to address the challenging issues of the MR/MI population.

Finding 8.5: Forty-two per cent of all residents live in congregate living centers housing more than 17 residents.

Recommendation: Continue to support the goal of smaller numbers of persons living together.

DMHMRSAS Response: DMHMRSAS and CVTC support the goal of smaller numbers of persons living together. The facility has worked diligently and effectively over the past years to move out of buildings, which no longer meet the needs of clients served, and to reduce the census on living areas. In the mid -70's, CVTC had a population of approximately 3,600; today the population typically is about 655 and the number of operational beds is at 711 (effective 2/1/01). Efforts will continue to transition clients ready for discharge back to the communities.

As clients are discharged, operating beds at CVTC will be reduced until the goal expressed in the Facility Master Site Plan is achieved: a census of 293 by 2008. Efforts to divert admissions from CVTC will continue. As vacancies occur at other state training centers, CVTC clients from those localities will be offered an opportunity to transfer to these facilities, thus further enhancing decreases in clients in living centers.

8.5 6 Month Status Report 07/01/01:
DMHMRSAS and CVTC continue to support the goal of small numbers of persons living together. Since July 13, 2000, nineteen (19) clients have been discharged. Currently, four (4) clients are transitioning back to their communities. There also are ten (10) additional individuals who have already been approved/funded for waiver services. Since July 2000, CVTC has had some success in transferring clients to a Training Center in their home community: ❑ two (2) clients have been transferred to Southwestern Virginia Training Center; and another client will be transferred there in August 2001. ❑ a client was transferred to Southeastern Virginia Training Center in June 2001;

and

- a client will be transferred to Northern Virginia Training Center on July 25, 2001.

Currently, 86% of clients live in congregate living areas housing less than 17 clients. As of July 24, 2001, CVTC has a census of 636.

OIG Comment- Interviews revealed that the facility continues in its efforts to decrease the numbers of persons in congregate living situations. This is accomplished primarily through discharges and transfers. This finding is ACTIVE.

8.5 6 Month Status Report 1/01/02:

CVTC's census as of 1/3/02 is 625. We continue to downsize through admission diversions, discharges, and transfers to other facilities (see response to Finding 8.2). CVTC continues to work with CSBs, families and providers regarding the transition of clients back to their communities. CVTC utilizes the Discharge Protocols process as a means for CSB's to focus on those clients who have been identified as "Discharge Ready". Four clients have been discharged since July, and there are 4 clients now on leave, pending discharge. There are fewer waiver slots available for client placements; however, 10 clients currently have waiver funding.

OIG Comment – Interviews with administrative staff revealed that the facility is continuing in their efforts to decrease living unit size through transfers and discharges. The facility has established an initial target goal of having unit sizes less than 17 people, with the ultimate goal of units housing ten or less. While we recognize that the facility is working on this goal, because these crowded conditions are not in the best interest of these very impaired and intensive residents, this finding remains ACTIVE.

8.5 6 Month Status Report 07/01/02:

CVTC's census as of 7/31/02 is 609 (this includes a client on special hospitalization from Catawba Hospital who is expected to return to Catawba during the next several weeks and an emergency care admission who is expected to leave within 21 days). CVTC has continued to downsize through admission diversions and discharges. Eleven (11) clients have been discharged since 1/02/02, and there are four (4) clients now on leave, pending discharge. Additionally, two clients were transferred to other facilities, one to Catawba and one to Southeastern Virginia Training Center.

As of July 31, 2002, only 16% of all clients at CVTC reside in congregate living areas housing more than 17 clients.

- 65% of all clients live in congregate living areas housing 15 or fewer clients.
- 19% of all clients live in congregate living areas housing 16 - 17 clients.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
(Formerly, DeJarnette Center)
INITIAL PRIMARY INSPECTION
APRIL 28-30, 1999
OIG REPORT # 01-99

Finding 8.2: DeJarnette is currently without a clearly articulated mission regarding its niche in the spectrum of providers of public and private mental health services to children.

Recommendation: Articulate clearly the intended role for DeJarnette Center within the Treatment spectrum of public and private providers for Children and Adolescents in the Commonwealth of Virginia. Adopt admission, discharge, and outreach policy that mirrors this expectation.

DMHMRSAS Response: Since Dr. Everett's visit to the Center, the Management Team of the Center has been working with the DMHMRSAS on articulating the future mission of the Center. In April and June 1999, the Center met with staff of the DMHMRSAS including the Deputy Commissioner to address issues surrounding the closing of Central State Hospital's Adolescent Unit and DeJarnette's role in serving the needs of adolescents from HPRs IV and V. The Center began accepting adolescents from those areas in June. The DMHMRSAS has also provided the Center with additional resources to fulfill the need for increased services at the Center as well as meeting the needs for the Center's new mission for community outreach and support. The mission statement of the Center and the policies governing the processes of the Center will change as needed to reflect these new roles by July 2000.

6 Month Status Report: 7/1/01
The name of the center changed in May 2001 to become the Commonwealth Center for Children and Adolescents (CCCA). CCCA will continue to serve the acute care needs of children and adolescents requiring psychiatric hospitalization when there are no other community resources available. The Center will continue to promote shortened lengths-of-stay and to seek discharge options in children's communities to the extent possible. The Center will continue to dialogue with the DMHMRSAS on revisions and refinements of this role. The Center continues to be licensed under the Core Standards and is accredited by the JCAHO under the Behavioral Healthcare Standards.

OIG Comment- Since the inspection in April 1999, the Center has been working with the Central Office to more clearly define its Mission and role within the service delivery system. The May 2001 follow-up inspection revealed that a retreat has been scheduled for the summer of 2001, to continue to address this issue. While it is recognized that Mission and Value clarification should be a dynamic process at any agency, the persistence of this lack of clarity at the Center is particularly critical to the operation of Virginia's primary child and adolescent treatment facility. Unclear definition of role and purpose undoubtedly influences all aspects of clinical care, program development and administrative operations. This finding has also been commented in finding 5.1 (OIG Report # 17-00). This finding is ACTIVE.

6 Month Status Report: 1/1/02
CCCA has worked with the DMHMRSAS to more clearly define its role in the Virginia mental health service delivery system. The mission of the facility as articulated by the Center and the DMHMRSAS is clearly stated to be acute intensive psychiatric in-patient treatment and stabilization services for children and adolescents.

OIG Comment- Interviews with administrative staff conducted during the March 2002 inspection indicate that management staff has a clear sense of this mission, which is acute, intensive psychiatric in-patient treatment and stabilization services for children and adolescents. It is now incumbent on them to continue to develop the clinical practices, which are designed to assess, stabilize and promote successful adaptation into the community. Because this is a new mission statement, the OIG would like to monitor this issue. This finding is ACTIVE.

6 Month Status Report: 7/1/02
DMHMRSAS appreciates recognition by the Inspector General of CCCA's clarity of its role in the state mental health system. CCCA staff will continue to review its internal processes to develop and maintain treatment services that meet the acute intensive psychiatric in-patient treatment and stabilization needs of the children and adolescents served by the Center.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
(Formerly, DeJarnette Center)
SNAPSHOT INSPECTION - OCTOBER 3, 1999
OIG REPORT #10-99

Finding 3.1: Professional Staff (primary therapist) services are not available for families on weekends.

Recommendation: Arrange professional staff schedules in order to accommodate the needs of families including evening sessions and weekend appointments.

DMHMRSAS Response: In October 1999, the Management Team informed the professional staff of their duty to meet the individual needs of families regarding evening and weekend appointments. Clinical staff schedules are arranged to accommodate the specific requests of families to meet at times most convenient to them. Clinical discipline heads will follow-up with individual staff.

6 Month Status Report: 7/1/01
Clinical staff continues to provide off-hours and weekend meetings and therapies as

needed and as requested by families and community representatives.

OIG Comment - *As of May 2001, the need for and lack of regular, professional staff presence during evening and weekend hours to better accommodate the schedules' of families' has not diminished or been corrected. Staff has made minimal concession to this issue by agreeing to be available on an " as needed" basis, but it continues to be evident that there is resistance to making these accommodations. It has been noted repeatedly that an acute care facility treating children and adolescents needs to maximize the clinical time available for this population and their families, especially in light of decreasing lengths of stay and the need for proactive discharge planning. This finding is* ***ACTIVE****, see finding 3.3 (OIG Report # 1-99).*

6 Month Status Report: 1/1/02

The clinical staff is aware of the great distances that families and community staff must travel in order to be present at the Center. The clinical staff adjusts their work hours to meet the needs of these individuals. The social workers serve on call on a rotational basis every evening, night and weekend, coming to the Center whenever there is a family in need of social work intervention. Social workers as a group actually work an average of 22 hours outside of normal business hours each week to meet the needs of families. Each psychologist arranges family therapy times that include evening and weekend hours. In addition, they respond to emergency needs when they occur. Each psychologist works an average of 4 hours each week outside of normal business hours.

The family and patient satisfaction feedback indicate that the Center social workers and psychologists are perceived as being available to children and families at times that are convenient to the families. To enhance feedback on the family satisfaction survey, CCCA will add an additional item to more specifically address this issue (e.g., "I found staff to be considerate of my needs in scheduling family therapy sessions"). If results begin to indicate that families are not satisfied with service availability, then other clinical staff scheduling options will be implemented.

At this time, CCCA does not plan to assign clinical staff to work evenings and weekends on a fixed or rotating basis, because it is neither cost effective nor time efficient to do so. Whenever clinical staff work evenings and weekends, time spent with the treatment team is diminished during high intensity, regular business hours. The facility will continue to monitor family satisfaction with services.

OIG Comment- *During the March 2002 inspection, interviews with staff and review of printed data and other materials indicate that this continues to be an issue. Most notable was the Case Mix-Special Populations document (dated 3/6/02) in which facility staff concluded that the CCCA is an acute care facility and lengths of stays are shortening with almost 50% of last year's admissions being discharged in less than three weeks. It is troublesome that high intensity treatment time would be contained in regular business hours. Instead, it would seem more logical to create higher intensity treatment opportunities during increased hours, especially some weekend times, since the total length of stay is abbreviated compared to previous years.*

A telephone survey of three private, acute care child/adolescent inpatient programs in Virginia indicate that the Commonwealth Center differs from the others in regard to lack of structured professional staff availability during evening and weekend hours. This finding remains ***ACTIVE.***

6 Month Status Report: 7/1/02
The CCCA staff strives to be available and provide services to children and families throughout the seven days of the week. Nurses, direct care staff, and activities therapy staff continues to provide active therapeutic treatment interventions seven days per week. Physicians, psychologists, and social workers reschedule their hours and/or provide on-call services throughout the seven days, 24-hours per day. CCCA added a question to our Family Satisfaction Survey specifically related to scheduling family therapy times. The most recent (May 2002) Satisfaction data indicate that all families agreed that their needs were considered when scheduling times for family therapy. CCCA will continue to monitor this issue and make changes as indicated.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
(FORMERLY DEJARNETTE CENTER)
PRIMARY INSPECTION FOLLOW-UP: MARCH 30, 2000
OIG REPORT # 17-00

Finding 5.1: DeJarnette and the Central Office have made progress in the articulation of a clearer role for this facility.

Recommendation: Continue to create an identity as a quality resource for the care and treatment of children and adolescents.

DMHMRSAS Response: DMHMRSAS appreciates the Inspector General's acknowledgment of progress in the area of clarifying the role of DeJarnette Center.

At the March 16, 2000 meeting between the Deputy Commissioner and DeJarnette leadership, the mission of DeJarnette Center in providing acute inpatient psychiatric services to children and adolescents was affirmed. Guided by this mission, the role of DeJarnette Center is to stabilize children and adolescents experiencing psychiatric crisis, and prepare them as quickly as possible for either return to the community or transition to other facilities for the provision of long-term care. DeJarnette Center will continue to operationalize its newly affirmed role as a provider of acute inpatient psychiatric services. The current goal is reduce to reduce average length of stay to twenty-five days, from the average of 34 days in FY1999.

6 Month Status Report: 7/1/01
The name of the Center changed in May 2001 to become the Commonwealth Center for Children and Adolescents. CCCA will continue to serve the acute care needs of children and adolescents requiring psychiatric hospitalization when there are no other community resources available. The Center will continue to promote shortened lengths-of-stay and seek discharge options in children's communities to the extent

possible. The Center will continue to dialogue with the DMHMRSAS on revisions and refinements of this role. The Center continues to be licensed under the Core Standards and is accredited by the JCAHO under the Behavioral Healthcare Standards.

OIG Comment – Based on the May 2001 follow-up visit, it has been noted previously that this facility has history of reviewing its mission. Since it is the primary of only two state operated facilities for children and adolescents within Virginia, it is particularly important that its' role be clearly understood. The facility has scheduled a retreat to re-evaluate its' mission and values statements within the month of June 2001. It is recognized that the Center has undergone considerable change and challenge within the larger context of the changing roles of the public and private mental health care system, over the past 5 years. Since this undoubtedly influences the care available for this population it is especially critical that this issue be resolved. Interviews reveal that confusion regarding the facilities' mission is ongoing and creates anxiety among staff. This finding is ACTIVE; see finding 8.2 (OIG Report #1-99).

6 Month Status Report: 01/01/02

Key staff of the Center participated in a mission clarification retreat in June 2001. The work resulted in a new mission statement for the facility. Although a mission statement alone does not fully clarify the Center's role in the larger child and adolescent mental health services for Virginia, it does allow us to focus our vision as the sole free-standing public mental health facility in the Commonwealth. The Center has worked with the DMHMRSAS to more clearly define its role in the Virginia mental health service delivery system. The mission of the facility as articulated by the Center and the DMHMRSAS is clearly stated to be acute intensive psychiatric in-patient treatment and stabilization services for children and adolescents. Through our many contacts with community staff and staff of other government agencies, we are able to assist in clarifying for them the role of the Center within the continuum of mental health services for children and adolescents.

OIG Comment- Interviews with administrative staff conducted during the March 2002 inspection indicate that management staff has a clear sense of this mission, which is acute, intensive psychiatric in-patient treatment and stabilization services for children and adolescents. It is now incumbent on them to continue to develop the clinical practices, which are designed to assess, stabilize and promote successful adaptation into the community. Because this is a new mission statement, the OIG would like to monitor this issue. This finding is ACTIVE.

6 Month Status Report: 7/1/02

DMHMRSAS appreciates the Inspector General's recognition of CCCA's clarity of its role in the state mental health system. CCCA staff will continue to review its internal processes to develop and maintain treatment services that meet the acute intensive psychiatric in-patient treatment and stabilization needs of the children and adolescents served by the Center.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
(Formerly DeJarnette Center)
OIG REPORT #23-00

Finding 3.2: Plans to operationalize a new psychosocial rehabilitation program are expected to be implemented by June 19, 2000.

Recommendation: None at this time. We look forward to reviewing the progress of this program.

DMHMRSAS Response: DMHMRSAS appreciates the Inspector General's acknowledgement of DeJarnette's creation of a new psychosocial rehabilitation program. The proposed steps to ensure the development of activities that have a clear treatment focus (as outlined above) will assure on1going progress in implementing psychosocial rehabilitation activities.

6 Month Status Report: 7/1/01
The Activities Staff of the Center implemented a modified treatment mall during the Summer 2000. This approach was very successful in providing active treatment offerings to all children of the Center. This program was modified in the Fall 2000 to adjust for the individual needs of clients served by the Center. The AT staff adjusted their schedules in order to provide active treatment in the evenings and on weekends. AT staff continue to implement a variety of therapeutic activities specific to the needs and treatment goals of each child.

OIG Comment: The facility has tried different models for improving active treatment. It did initially offer a modified treatment mall during the summer of 2000, and continued the schedule of recreation and rehabilitation services once the school year resumed, during evenings and weekends. Review of materials and staff interviews, during the May 2001 follow-up inspection, reveal that the Center has returned to a unit-based model whereby regularly scheduled activities are operating the evening and weekend hours. Instead of offering these activities during the upcoming summer of 2001, the Center has contracted with local school personnel to provide an enrichment program focusing on the arts and sciences. Administration informed the team that curriculum materials have been ordered by the Activities Therapy department, and staff mentioned that they have been reviewing a Life skills curriculum that has been purchased by the facility by the SA coordinator. One concern about this menu of activities is that no structured curriculum has been formulated which outlines the goals and objectives for each topic. This creates difficulty in accurately evaluating whether and which of the services delivered can be demonstrated as having a useful effect on a consumers' identified problems. There is ongoing concern that these activities do not have a clear mental health acute care therapeutic focus and may not be individually tailored to meet the unique needs of a particular child. This finding is ACTIVE; see finding 3.2 (OIG report # 1-99); finding 3.3 (OIG Report # 10-99); finding 2.4 (OIG report #17-00); 3.1 (OIG Report # 22-00).

6 Month Status Report: 1/1/02
In the Summer 2001, the Center continued to operate the active treatment program during the evening and weekend hours as well as provide individual active treatment and group interventions during those hours so that children received the full array of interventions

needed for their quick stabilization and return to their families and communities (see Finding 3.1 Status Report above). The academic enrichment program offered was to provide a school-based link for children during the month of July so that they had opportunities to build academic skills (somewhat likened to adults being provided continuing job skills development at adult facilities). The staff of this program provided a wide variety of structured, positive, and proactive groups around the topics of art (and art therapy), social studies and peer relations, language arts and cooperative learning, science/math and academic skill development, and physical education and physical health skill development. This was a very successful program with extremely positive feedback given by both children and clinical staff.

Along with the Summer Enrichment Program, groups continued to be offered that were both unit-based and cross-unit in order to provide many simultaneous opportunities for individual children to receive the groups they need or request. Activities therapy staff continue to work evenings and weekends to provide a full array of relevant active treatment interventions outside of school hours. The Center is now developing a manual that will outline the goals and objectives of each active treatment group (completion date is March 2002).

OIG Comment - The March 2002 inspection included interviews with administrative and direct care staff; tours and observation of the activities involved in the PSR; interviews with six patients; review of educational materials; and documentation in records. The direct care staff, who perform the majority of the active treatment program functions, have a lot of enthusiasm and a willingness to learn new skills. Those interviewed questioned whether they had been adequately trained or skilled to provide the level of intervention required in active treatment.

The amount and quality of documentation of the activities has improved. The records contain a brief description of the individual patients participation or lack thereof. The treatment plans delineate which activities are prescribed and these are related to assessment and diagnosis. All of the patients interviewed had difficulty verbalizing how the various activities in which they were engaged were linked back to their treatment plans or the reasons for their hospitalization. In comparison with the remainder of the mental health facilities throughout the Commonwealth, the psycho-social rehabilitation component of active treatment is far less individualized. When treatment is not individualized it becomes less beneficial in terms of discharge preparedness and successful community adaptation. This finding remains ACTIVE.

6 Month Status Report: 7/1/02

CCCA will continue to build the active treatment programs offered to the children and adolescents served according to their individual treatment needs in coordination with the goals established by the treatment teams. CCCA strives to provide a wide array of groups that include specific interventions related to the individual treatment plans. The group interventions are determined for each individual child by the members of the treatment team, including the unit clinical director, the psychiatrist, nurses, activities therapy staff, social workers, direct care staff, and teachers in joint treatment planning and review meetings.

CCCA will work with its clinical teams to develop a process to help children more clearly understand and articulate how the various treatment activities are linked to their treatment plans.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS
SNAPSHOT INSPECTION
MARCH 6, 2002
OIG REPORT #56-02

Finding 1.1: Overall the facility was clean and well maintained but institutional in appearance.

Recommendation: Continue to assure that the maintenance of the overall facility includes the general upkeep of the bedroom areas, as previously planned. Consider adapting the use of visual materials for decoration noted in the school area in the living areas.

DMHMRSAS Response: DMHMRSAS appreciates Dr. Everett's positive recognition of the CCCA's environment. CCCA is engaged in several ongoing activities to maintain a more "homelike" environment. The Center will seek and frame children's artwork for display in the dayrooms of each unit. The staff will continue to encourage children to personalize their individual bedrooms to make the environment less institutional within guidelines of fire safety. CCCA staff will also continue to expect that children maintain their rooms in a tidy manner.

6 Month Status Report: 07/01/02

CCCA staff continues to maintain a 'homelike' environment. Art pieces have been collected and will be placed on the walls of living areas on units after they are framed. CCCA staff continues to encourage children to maintain their bedrooms.

Finding 2.2: Staff had a wide range of clinical orientation to the management and treatment of children in this facility.

Recommendation: Work to promote clinical consistency through creating opportunities for mentoring and modeling therapeutic interaction with staff from second and third shifts.

DMHMRSAS Response: DMHMRSAS believes that consistency in treatment is paramount to optimal provision of psychiatric services and to the eventual positive outcomes for children. Considerations founded in normal human development provide the basis for interactions between staff and children. Staff approaches to children focus on their positive behaviors and positive interactions rather than on pathology. During orientation, all employees are introduced to the CCCA mission and values including the CCCA philosophy of treatment of children and adolescents. New staff is trained on etiology of clinical disorders in children, symptoms of clinical disorders, and use of positive clinical interventions with children. New staff receives crisis intervention training and all staff members are provided annual recertification in this area. Staff also receives ongoing supervision and mentoring through their supervisors.

In March 2002, the Center began a formal unit-based training program that involves clinical leaders and other unit staff. These training events are designed to build staff's understanding of the treatment needs of children. The trainings have included such topics as transference/counter transference, interventions with children having personality disorders, restrictive interventions with children, and use of mediation skills with children. With the clinical staff and the Unit Program Directors involved in this process, the Center will continue to build and sustain this effort. Through competency assessment of staff, supervisors are able to identify training needs of individual staff members. Competency assessment at the Center that is directly linked to the performance evaluation process is a valuable tool to identify training needs of individuals.

The clinical staff meets every assigned workday with staff of both first and second shifts to provide on-going clinical consultation. Direct care staff or their supervisors are able to attend treatment-planning meetings. To the extent possible, these meetings are scheduled at times when the largest number of staff is available to attend.

In order to assist children in their educational requirements (including remedial instruction as needed) and to provide them with normalized activities, school takes place between the hours of 8:30 am and 2:45 pm weekdays. Since the primary focus of services provided to children at the Center are psychiatric stabilization and assessment, the clinical staff provide individual and group therapies during school hours when children are most alert and responsive to such interventions. These are scheduled in advance in communication with the education staff so that teachers and therapists are working together to provide both education and therapy services. Other active treatment interventions such as psychoeducational groups, substance abuse groups, therapeutic recreation, music therapy, physical recreation, and relaxation groups are scheduled in the evenings at times most conducive to such activities.

6 Month Status Report: 07/01/02
CCCA clinical staff members continue to be mentors and guides for the staff on their respective units in a variety of ways. They participate as active members of the afternoon shift exchange meetings; they reschedule work hours as needed to meet with staff; and they provide clinical assistance by phone when needed, and respond to staff questions and concerns regarding the care of children served. Clinical consistency is enhanced through communication at treatment team meetings and treatment review meetings where representatives from all disciplines associated with individual children are present.

Finding 3.1: Patients have access to education and evening activities.

Recommendation: Enhance evening activities designed to meet the individual treatment needs of the patients. Review the practice admitting adolescents to the children's units.

DMHMRSAS Response: DMHMRSAS is committed to the provision of active treatment and age-appropriate treatment for all clients in our system. CCCA provides active treatment in the form of psycho-educational groups, recreation therapy, music therapy, and substance abuse groups in the evening and during weekends. CMS (formerly HCFA) guidelines require a minimum of 21 hours of active treatment per child per week (not including individual and family

therapy). The Center consistently exceeds that 21- hour minimum of active treatment hours. The staff members involved in planning and leading active treatment groups are also members of the clinical teams for the children served. They determine the need for groups based on treatment goals and objectives written for each individual child as established by the clinical team. Because the Center serves a wide variety of children of different ages, including children with mental retardation and (at times) autism, it has been necessary to plan a wide variety of interventions for all children at the Center. The CCCA Activities Therapists and their supervisors have developed a comprehensive listing of all the types of groups currently offered at the Center. They plan additional groups as indicated by the changing needs of the children. The Center will continue to monitor the number and types of active treatment groups offered to children. New groups will be formed as needs arise.

CCCA has two units with 12 beds each for a Children's Program and for an Adolescent Program, for a total of 48 beds. Placement on these units is determined by age, developmental level, and bed availability. The Admissions staff consults with program staff to the extent possible in determining where a child should reside while at the Center. Sometimes, when beds on specific units are full, the Center will place a child on a unit with an available bed. This may mean that a 16-year-old adolescent may reside on the pre-adolescent unit that typically serves children from ages 12 to 14. Likewise, if the Children's Program units are full, a 13-year-old child may need to reside on an Adolescent Program unit which typically serves children ages 14 to 17. When these mixes occur, the clinical team for the child works with the other teams to plan group interventions and activities with his/her chronological peers to the extent possible. Children admitted to a different age unit may be relocated to a more age appropriate unit when a vacancy occurs, as determined by needs of the child and therapeutic progress. This occurs in communication with the child, the family, and others involved in the care of the child.

6 Month Status Report: 07/01/02

The CCCA Activities Therapy and other staff continue to provide more than the minimum of 21 hours of active treatment per child per week. The AT staff continues to discuss treatment needs of individual children with clinical treatment team members and plan interventions for individuals that are appropriate to their needs. The Clinical Staff Executive Committee has reviewed and made recommendations to the comprehensive listing of all groups offered by the Activities Therapy and Nursing staff of the CCCA. This list serves as a menu of options available for group and individual interventions with children as determined by their respective treatment teams The management team of CCCA will continue to monitor though quarterly reviews by the Clinical Program Services staff.

Admissions staff continues to work with unit clinical teams in determining the best placement of newly admitted children and adolescents. In the infrequent event when the CCCA must place a child or adolescent on a unit with different aged children or adolescents, the staff consult with one another to provide the best therapeutic care that meets the needs of the individual. The staff of CCCA assess the individual's needs for safety and security as well as assess the level of dangerousness toward others. The staff determines the best placement option taking into account multiple variables.

Finding 3.2: The observed use of restraints was inconsistent with the current D.I. recommendations that restraints either be utilized for acute emergency management or as a formalized part of an approved behavioral Management program.

Recommendation: Reconcile the existing the Departmental Instruction on Seclusion and Restraint with practice at CCCA. Consider consultation on particularly challenging individuals with in-state resources such as behavioral consultation teams in place at other facilities.

DMHMRSAS Response: The Department appreciates the concern expressed regarding the use of mechanical restraint [redacted]. The Departmental Instruction on seclusion and restraint was written primarily for adult populations served at the psychiatric hospitals in the DMHMRSAS system. Federal standards for seclusion and restraint for children differ. Therefore, the Center was granted a waiver from the Departmental Instruction in 2001. The seclusion and restraint policy of the Center was developed with Central Office staff and includes all of the requirements established by JCAHO, the State Human Rights Regulations, and the federal government.

In November 2001, the DMHMRSAS issued a revision of the State Human Rights Regulations. In [redacted] 2002, the Center admitted the adolescent referenced in the OIG report. [redacted]. When determining the intervention needs for this individual, the Center determined that mechanical restraint would be used on an emergency basis to protect others from this [redacted] adolescent. [redacted] The safety of others as well as the rights of others to be protected from harm were strong clinical considerations [redacted].

The Center's internal seclusion and restraint policy prohibits the use of seclusion or restraint as part of a behavior management plan [redacted]. In exploring the requirements of the new State Human Rights Regulations, the Center determined that use of mechanical restraint could continue if the team followed regulation 12 VAC 35-115-110.C which provides three options for the use of seclusion or restraint: 1) emergency use; 2) use as determined and documented by a qualified professional involved in providing services to the individual; or 3) as part of a behavior management plan. The Center staff determined that the situation for this adolescent fit the criteria stipulated under 12 VAC 35-115-110.C.2. a through d. The unit psychiatrist and other members of the clinical team initiated mechanical restraint based on these criteria as well as a comprehensive assessment of his functioning. All monitoring and documentation of the use of the intervention meets the requirements established by CCCA policy, JCAHO and federal standards, and the State Human Rights Regulations. [redacted]. The Center will continue to strive toward the reduction of the use of seclusion and restraint with its

patient population and will continue to meet the requirements for the use of these procedures for its specific population of clients.

6 Month Status Report: 07/01/02
Through the Restrictive Interventions Committee, a standing committee of the Clinical Staff, CCCA will continue to monitor the use of seclusion and restraint and will continue to meet state, federal, and JCAHO requirements for use. Recent record reviews of cases involving use of seclusion and restraint were made by Dr. Jeffery Geller, consultant to the DMHMRSAS, as part of a comprehensive assessment of Center services and processes requested by the DMHMRSAS; and through a scheduled 'mock' JCAHO survey by a state expert. Both site visit reports stated that the Center demonstrated significant compliance to state, federal, and accreditation requirements for the use of seclusion and restraint. Dr. Geller's report indicated that CCCA has a seclusion and restraint policy that meets professional standards. He suggested that CCCA fine tune the process for tracking threshold requirements for reviewing seclusion and restraint contemporaneous with treatment. The Restrictive Interventions Committee at the CCCA has responsibility for monitoring this suggestion.

Finding 3.3: For snack time, the majority of patients chose to purchase a canned soft drink and either potato chips or a candy bar.

Recommendation: Review the appropriateness of the choices available for the children and adolescents during evening snack time.

DMHMRSAS Response: Regular meals and both afternoon and evening snacks for the children served by the Center are planned by WSH Registered Dieticians. They have included children in the planning of meals and snacks by means of periodic food preference surveys. OIG comments will be forwarded to the WSH dieticians. Over the years, the children's menu has been revised many times to meet the changing needs and preferences of the children. The menus resemble those found at other facilities serving children and adolescents. The dieticians attempt to balance nutritional needs with selections that are acceptable to children. Considering the short lengths-of-stay for the majority of children and the need to assure that large quantities of food are not wasted, the dieticians have planned meals and snacks that are both nutritional for and appealing to children.

The Center staff has taken steps to regulate items available to children as well. Bonus Point Store items contain selections that minimize the use of candy and chocolate as well as promote the use of non-food items or healthy food such as granola bars. Children are able to access the vending machines that are available to staff and visitors of the Center. The products offered in vending machines are ones that are available through the vending company. The Center will negotiate with the company to seek other products for the machines including juice drinks and healthier snacks. If those items are not available through the company, then the Center will seek another vendor.

6 Month Status Report: 07/01/02
Staff will continue to monitor the snacks that are available to children at CCCA. The Center is working with WSH food services staff and with the local contract snack provider to increase the healthy snacks and drinks available to the children at CCCA. WSH was able to obtain modification of available snacks to add more "nutritional" items to the selections through the local snacks vendor.

EASTERN STATE HOSPITAL
RESPONSE TO PRIMARY INSPECTION
SITE VISIT OF SEPT. 25-26 & OCT. 3, 2000
OIG REPORT # 31-00

FINDING 1.2: Challenging placements were identified as one of the primary issues facing the human rights advocates providing services for the acute admission unit, Building 2.

Recommendation: Maintain dialogue with facility, Central Office and the community regarding issues associated with community re-integration.

DMHMRSAS Response:

6 Month Status Report: 7/1/01
Eastern State Hospital has been participating in on-going meetings with Central Office and HPR-V CSBs to resolve barriers to placement and improve the discharge planning process. Utilization review of 100% of the patients in Admission Building is being conducted weekly to identify discharge ready patients. Discharges have increased as a result of these efforts. Lengths of stay have also been reduced.

OIG Comment - Interviews revealed that this facility continues to deal with challenges associated with being able to match patient needs with available community resources. This finding is ACTIVE.

6 Month Status Report: 1/01/02
ESH is implementing the new statewide Discharge Protocol by January 2, 2002. The initial hospital training has been completed and the Clinical Operations Director is working closely with Central Office to continue to improve the discharge planning process. During this report period clinical social workers previously assigned to the Hospital Community Liaison/Resource Department were reassigned to programs, with the focus on preparing patients for discharge and identifying needs to be addressed upon discharge. This action was the result of statewide implementation of the Discharge Protocol that places responsibility for discharge resource identification on CSBs. The median LOS was reduced by five days in October hospital-wide and it is currently 14 days in Acute Admissions. The Clinical Social Work Director continues 100% utilization review with the Clinical Operations Director to maintain and/or decrease LOS.

OIG Comment – Interviews indicated that the facility has demonstrated initiative in addressing difficult placement issues with respect to substance abuse and mentally retarded patients. As outlined in the status report, OIG team members were informed of increased community contact regarding placement issues and a restructuring within social work for focusing on preparing patients for discharge. These actions coupled with the initiation of the statewide Discharge Protocols by all facilities are evolving. This finding is ACTIVE.

6 Month Status Report: 07/01/02
The Clinical Operations Director meets monthly with the case manager liaisons from the nine CSBs served by ESH, the Program Social Work Directors, and Central Office staff, to problem-solve and improve the Discharge Process. The Utilization Review Coordinators and Clinical Operations Director collaborate on all U.R. denials that effect discharge. There is ongoing review of all patients in the Hospital who are clinically ready for discharge and a new computer program has been developed and is in the process of being implemented to provide daily updates on all patients regarding clinical discharge ready status. The May 2002 Management Information Systems Report showed an increase in the number of discharges from January 2002 to May 2002.

Finding 2.2: Continuous observation of patients in seclusion is not a current practice in Building 2.

Recommendation: ESH needs to review its policy regarding seclusion and update it in terms of consistency with new departmental instructions.

DMHMRSAS Response: ESH policy TX-450-35, *Emergency Use of Seclusion or Restraints*, is currently under revision to be consistent with Departmental Instructions and policies; and it will be finalized and implemented January 1, 2001.

6 Month Status Report: 7/1/01
ESH policy TX-450-35, *Emergency Use of Seclusion or Restraints,* has been revised and coordinated with all required clinical committees. As required by Departmental Instruction, a draft copy was forwarded to DMHMRSAS for approval prior to implementation. Policy will be implemented immediately after Central Office review. Estimated completion date is August 15, 2001.

OIG Comment - Interviews and observations indicated that the facility continues the practice of fifteen-minute observations of patients in seclusion instead of continuous observation. On the date of the inspection, a patient in seclusion was noted by the OIG team to be lightly tapping on the door asking if someone could "please talk to me". Although he appeared to be calm and appropriate, there was not a staff member present to observe or assist him. This practice places the patient at risk for harm and the facility at risk for liability of actions that occur while the

patient is not being observed. One staff member volunteered that when the patient was in seclusion, it was the only "break" they had from him. Record reviews demonstrated that he was a challenging patient and often required one on one due to impulsive aggressive behaviors. Staff indicated that delays from the Central Office in approving the draft policy governing seclusion and restraint prohibited its implementation. This finding is ACTIVE.

6 Month Status Report: 1/01/02
The facility has drafted a new policy TX-450-35 has been completed and revised in accordance with the new DMHMRSS DI. The policy has been disseminated and is currently being taught to all direct care employees.

OIG Comment – Interviews and observations during the follow-up tour revealed that staff do not practice continual observation while patients are in seclusion. To the knowledge of the OIG, ESH is the only DMHMRSAS mental health hospital that does not practice continual observation. This finding is ACTIVE.

6 Month Status Report: 07/01/02
Staff members have been informed on the need to adhere to the practice of continual observation of secluded patients. We have made the changes to our policy and staff are continually monitoring seclusion and entries recorded on the patient monitoring sheets. Quality Management monitors six items on the sheets and results of the monitoring show an average of 97% of observation activities are documented on the patient monitoring sheets.

Finding 2.3: There was not any documented evidence that routine debriefing of patients regarding seclusion events occurs.

Recommendation: Formalize the process of post-seclusion debriefing of both staff and patients including procedures for documentation. This is consistent with new Departmental Instructions.

DMHMRSAS Response: The expectation and procedures for patient and staff debriefing following all incidents of seclusion and restraint has been included in draft ESH Policy TX-450-35, *Emergency Use of Seclusion or Restraints,* as noted above, which will be implemented on January 1, 2001. In addition, the Nursing Practice Council will update the Nursing Standard Operating Procedure to include debriefing guidelines and documentation standards. All staff will receive in-service training in these guidelines and standards.

6 Month Status Report: 7/1/01
Revised policy is pending review and approval by the Central Office, Office of Health and Quality Care. The Nursing Practice Council developed a Seclusion/Restraint Debriefing Form/TPC Note to be used as a debriefing tool following episodes of seclusion or restraint.

OIG Comment - The facility is developing a form to be placed in the patient record that will provide a format for the routine documentation of debriefing with the patient following the use of seclusion and/or restraint. There was limited evidence in the records reviewed of efforts to conduct debriefings. Staff have reviewed this process and explored several options for conducting and documenting debriefings. This finding is ACTIVE.

6 Month Status Report: 1/01/02
Debriefing forms have been developed as part of our current Emergency Seclusion and Restraint Policy. Utilization Review Coordinators are monitoring the debriefing process by reviewing 100% of the seclusion or restraint events. Results of these reviews are reported at the monthly Quality Improvement Council meeting and to the supervisors of the patients' ward.

OIG Comment – Chart reviews has not indicated that the new form has been fully implemented within the facility. This finding remains ACTIVE.

6 Month Status Report: 07/01/02
Full implementation has occurred of the Seclusion/Restraint Debriefing Form and more attention is being undertaken to documentation of debriefing activities to assure all episodes are fully debriefed as required in the policy. Monitoring of debriefing activities currently shows a 89% compliance rate in acute admissions and a 100% compliance rate in psychosocial rehabilitation areas. Tracking shows monthly improvement in compliance rates.

Finding 3.6: Patients, dually diagnosed with both mental illness and mental retardation present a placement challenge for the facility.

Recommendation: Work with the Central Office in exploring alternate methods for meeting both the treatment and placement needs for this population.

DMHMRSAS Response: DMHMRSAS continues to develop strategies to better meet the needs of the MI/MR population. The Director of Health and Quality Care, has discussed this issue in-depth with the ESH Medical Director and with other state facility Medical Directors; and they continue to explore and disseminate best practices for treating this population. The Central Office of Mental Retardation also has provided technical assistance to both facilities and communities in addressing treatment and placement needs for the MI/MR population.

DMHMRSAS supports ESH's ongoing efforts to improve treatment for this population, which includes:

- Designating one facility social worker to work exclusively hospital-wide with the MI/MR population regarding placement issues.

- ESH treatment teams aggressively referring appropriate MI/MR patients to the Behavioral Management Committee for individualized treatment plans to address problematic behaviors, which impede patient placement in the community.
- ESH staff continuing to attend, training on the treatment and resources for this population.
- ESH Liaison Director attending monthly HPR-V meetings of the CSB MR Directors to enhance facility and CSB linkage for treatment and discharge issues.
- ESH obtaining regular consultation from, a nationally recognized MR Behavioral Consultant, as needed for specific dually diagnosed patients using tele-conference technology.

6 Month Status Report: 7/1/01
Upon admission of an MR patient, the DMHMRSAS Office of Mental Retardation, is notified via letter providing pertinent information, such as initial diagnosis on admission and results of any I.Q. testing available. A quarterly report is submitted denoting information on the above patients, including date of discharge, if applicable. Barriers to discharge continue to be aggressive patient behavior and waiver placement. A Clinical Social Worker was assigned on January 15, 2001 to track the dually diagnosed MI/MR population, inpatient adult population, and to promote facilitation of timely and appropriate discharges by working closely with the treatment teams and MR case managers. Facility staff attended MR training workshops, including Medicaid waiver training conducted by Behavior & Assessment Consultants. The Liaison Director and the MR/MI Social Worker have visited resource fairs to meet with service providers. The Clinical Operations and Liaison Directors attended individual services plan training and shared information with the MR/MI social worker and CSB staff. Training enhanced the hospitals ability to identify, pursue, and secure waiver entitlements. A monthly report is prepared listing patients, diagnoses, and discharge efforts during the reporting cycle. The Community Liaison Director attends monthly HPR-V MR Director's meetings to enhance/increase facility and community communications concerning the MI/MR population. CSB Directors now actively seek alternative placement for MR patients. A draft agreement between the Department and the CSBs will address the screening and placement needs of clients with MI/MR diagnosis. For individuals with dual diagnosis of MI/MR, both the admitting Mental Health Facility and the region's Mental Retardation Training Center shall confer to determine which institution can best serve the individuals needs.

OIG Comment - – Interviews indicated that this population continues to present a significant challenge to this facility. Administrative staff indicated that the majority of patients currently admitted and identified as exhibiting high-risk behaviors have both a diagnosed mental illness and mental retardation. This was also confirmed during staff interviews and record reviews.

Placement continues to remain a significant difficulty because of the behavioral challenges. This finding is ACTIVE.

6 Month Status Report: 1/01/02
Currently ESH has 22 adult patients with a Mild to Moderate Mental Retardation diagnoses. The new Discharge Protocol should assist in providing an ongoing mechanism to track this patient population relative to discharge. The Facilities Clinical Operations Director will continue to gather monthly progress reports on this population and work with the Hospital, CSBs and Central Office staff to develop appropriate placements outside the facility. In addition, a DMHMRSAS Central Office work-group has been established comprised of representatives of MR and MH facility directors and CO MH and MR and operations representatives to discuss strategies to address the growing population. A decision should be made by the Spring of 2002 regarding what avenues the Department will take.

OIG Comment – Interviews with staff indicated that this continues to be an ongoing problem. The facility continues to make contact with appropriate community providers in order to foster improved placement options. Resolution of this problem will require the Central Office address resources across the state for this challenging population. This finding remains ACTIVE.

6 Month Status Report: 07/01/02
Currently ESH has 16 adult patients with a Mild to Moderate Mental Retardation diagnosis. The new Discharge Protocol is used to provide an ongoing mechanism to track this patient population relative to discharge. The Facility's Clinical Operations Director continues to gather monthly progress reports on this population and work with the Hospital, CSBs and Central Office staff to develop appropriate placements outside the facility. In addition, a DMHMRSAS Central Office Task Force has been established, comprised of representative of MR and MH facility directors, Central Office MH and MR, and operations representatives to discuss strategies to address this growing population as well as community and CSB representatives. This Task Force has met once with the Director of the National Association for Duel Diagnoses, who provided a presentation on promising programs. The Steering Committee of that group is now meeting to identify statewide programs and to consider a Statewide conference and regional planning to address this population.

Finding 4.2: Nursing staffs frequently work mandatory overtime to meet current staffing patterns.

Recommendation: Continue to explore alternate ways of meeting the staffing needs of the facility while lessening the amount of mandatory overtime for staff.

DMHMRSAS Response: DMHMRSAS concurs and shares this concern about reducing mandatory overtime. At this time, the Office of Human Resource Development has identified

nursing recruitment and retention as a systemic issue among all our facilities. Central Office, therefore, is developing a centralized approach to this problem in order to raise the level of our efforts in nurse recruitment and retention system-wide.

The Central Office Director of Human Resource Development, is heading a joint facility and Central Office work group for that purpose. The Director is consulting with each facility's Directors of Human Resources and Nursing Services to coordinate potential initiatives.

In addition, ESH over the past months has been active in addressing the mandatory overtime issue through creation of a "Nursing Task Force" in September. This task force focuses specifically on nursing recruitment and retention issues. Accomplishments of this Task Force thus far include:

1. Meeting with nursing staff on all three shifts at the Change of Shift reports to explain Task force goals and objectives.

2. Developed, distributed, and reviewed the results of a survey sent to all nursing staff to help address recruitment and retention. The survey sought to identify specific factors of dissatisfaction among the nursing staff as well as to identify ideas and suggestions for improvement related to retention. Completed in late November 2000, the survey identified mandatory overtime and staff scheduling as the major concerns. The Task force is actively seeking viable solutions to staff concerns.

3. Developed several committees to evaluate and make recommendations regarding key staffing issues, i.e., scheduling staff by patient acuity by program rather than by HPPD.

4. A nursing Intern Program is being developed and will be advertised in the *Virginia Gazette* and the *Daily Press* after the first-of-the year in an effort to recruit nursing students. The colleges targeted will be: Hampton University, Christopher Newport University, Old Dominion University, and Norfolk State University.

In addition, on Saturday, December 2, 2000, ESH Human Resources and the Department of Nursing conducted an Open House for Recruitment of Nursing Service Employees. On-the-spot applications were accepted, and interviews were conducted. Tours of the facility were offered to those interested applicants. Fifty applications were received (out of 66 attendees), and 45 staff were hired. The new hires included nine Registered Nurses, seven Licensed Practical Nurses, and 29 Direct Service Associates.

6 Month Status Report: 7/1/01
The Director of Nursing is on three task forces to seek solutions to the recruitment/retention issues that affect licensed nursing and health services care workers. Listed are efforts underway to meet our staffing needs while attempting to reduce mandatory overtime for classified nursing staff: 1. Nursing Taskforce was established March 2000.

2. Bonus for working voluntary overtime began December 2000. Lists were posted in each building began January 2001.
3. Attendance bonus for DSAs began in December 2000.
4. Pilot use of voluntary overtime to reduce number of hours of unplanned leave in Medical Services began December 2000.
5. Nursing Open Houses were held in January and April 2001. Another is planned for August 25, 2001.
6. A Referral Bonus Plan and in-band adjustment recommendations were sent to Central Office Human Resource Department for approval, June 2001.
7. Developing a partnership with Thomas Nelson Community College to provide nursing related courses on ESH campus. Anticipated beginning date of classes is in fall 2001.
8. Nurse internship program began May 2001. Four RN applicants were hired in June 2001.

The Director of Nursing is a member of the DMHMRSAS Nurses Executive Group with Central Office Human Resources Office to address recruitment and retention issues at the state level. She is also a member of the Nursing Summit Taskforces on general recruitment, retention issues and recruitment of minority nurses in Virginia. The Nursing Taskforce Committee has been disbanded and a Recruitment and Retention Committee has been established. The first meeting is scheduled for August 7, 2001

OIG Comment - – Interviews revealed that this continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Even though interviews revealed that the facility has made an effort to recruit and retain nursing staff, there are 42 vacancies currently in nursing staff positions. The facility has been discussing the possibility of developing and implementing a nursing program with a local community college that would include internships and job placement options. During the past three months, the facility has initiated a program of voluntary overtime with a small degree of monetary benefit. Staff interviewed related that voluntary overtime is viewed as separate from mandatory overtime resulting in a member agreeing to do some voluntary overtime then learning that they are expected to work as much as 16 hours of overtime in addition. This finding is ACTIVE.

6 Month Status Report: 1/01/02

The following efforts have been made to help with nursing moral and retention:

1. Meetings were held with the nurses on all three shifts at the change of shift to discuss issues impacting nursing care.
2. As a result of the Nursing Service survey, voluntary overtime is encouraged and has increased. The survey reviewed issues such as recruitment and retention and the use of overtime.
3. ESH indicated a special taskforce was developed and reviewed three acuity systems for patient care. Staffing by patient acuity continues to be explored.
4. The Nursing Intern Program for nursing school students entering their senior year resulted in the recruitment of seven (7) nursing interns into the program in June 2001. The students returned to school in August 2001. The brochures (under revision) will be mailed to all nursing schools in Virginia in January

2002 for the summer 2002 program.

Open Houses were also held on Saturday, March 24, 2001 and Saturday, August 25, 2001 to recruit and interview for Nursing Services.

th Status Report 7/01/01 Updates:

1. The attendance bonus for DSAs continues.
2. The bonus for working voluntary overtime continues.
3. The pilot use of voluntary overtime to reduce the number of hours of unplanned leave in Medical Services has been successful.
4. The Nursing Open House planned for August 25, 2001 was held and was successful in recruiting DSAs.
5. The referral bonus plan for RNs, LPNs and DSA IIs was approved.
6. The nursing taskforce has been dissolved after completing the task of reviewing the overtime and recruitment issues which are being reviewed through the statewide taskforce.
7. An RN applicant through the recruitment process was hired July 30, 2001.
8. The partnership with Thomas Nelson Community College is currently on hold. Presently the College is reviewing their program accreditations

The Recruitment and Retention Committee meeting scheduled for August 7, 2001 was canceled due to the resignation of the Director of Nursing.

However, DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a day-long special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Subsequent meetings will be held over the next six months to develop strategies/recommendations for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the Secretary of Health and Human Services.

OIG Comment - Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. Nursing staff indicated that community facilities had become increasingly competitive making working "for the state" less attractive. In addition, staff interviewed related that voluntary overtime although viewed as separate from mandatory overtime results in nursing staff working as much as 16 hours of overtime per week. This finding is ACTIVE.

6 Month Status Report: 07/01/02

The facility is in the process of preparing to offer two (2) courses on ESH campus in collaboration with several administrative staff members from Thomas Nelson Community College. The response has been overwhelming in terms of interest by ESH staff. There are currently four (4) intern students from the surrounding colleges in ESH Summer Nursing Internship Program. One (1) RN who attended the

Internship Program last summer has been hired. This individual was motivated to become a certified nurse's aide after completion of the program last summer and has been working as a DSA II while completing her course requirements. Although minimal, this success is as a result of the Internship Program.

Meetings have been held with nurse management to clarify the use of voluntary overtime versus mandatory overtime.

Finding 8.1: Recruiting and retaining nursing staff has proven to be extremely difficult facility-wide.

Recommendation: Work with the Central Office in developing solutions to the overall and on-going shortage of nursing personnel at this facility.

DMHMRSAS Response: Concur. See response to Finding 4.2.

6 Month Status Report: 7/1/01

Recruitment and retention of licensed nursing staff is a nation-wide issue that we are addressing at the local and department level. See response to Finding 4.2.

OIG Comment - – Please refer to response in Finding 4.2. This finding is ACTIVE.

6 Month Status Report: 1/01/02

uman Resource Department provided the Office of Health and Quality Care in Central Office, with a notebook of studies and an update of activities to enhance recruitment of nurses at ESH. These include:

1. An In-Band Adjustment for Retention of 37 LPNs, effective 12/10/01 has been approved. This is of varying amounts and aims to bring the LPNs closer to the median salary for LPNs.
2. ESH is collecting data to support a new hiring range for DSA IIs, which would make ESH more competitive in the labor market.
3. ESH is reviewing data about RN IIs and is reviewing options at developing an In-Band Adjustment for retention.
4. The part time hourly pool of RN IIs has been enlarged from 14 and now stands at 18 FTEs.
5. RNs who retired from ESH are actively being recruited to work as WE-14 employees. A program was presented at the ESH Retirees Association and letters were mailed to retiree homes.
6. RNs who resigned from ESH are being recruited to return.
7. A revised brochure is being presented to mail to schools of nursing in Virginia to recruit senior nursing students to summer interns at the facility in 2002.
8. LPN vacancies were placed in continuous recruit.
9. The Educational Assistance Committee has approved several applicants for assistance to attend nursing school; these employees would owe ESH time as an

RN when they pass their nursing boards.

Retention efforts have focused on assisting nurses to transfer to other programs or units at ESH when there are vacancies and when the employee needs to work with different patients. The DMHMRSAS Central Office is addressing work-force needs system-wide through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. On December 14, 2001 the Committee sponsored a daylong special meeting, *Charting the Course*, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Nationally known experts provided information on workforce trends and on innovative strategies for developing and retaining workers in healthcare. Subsequent meetings will be held over the next six months to develop strategies/recommendations for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the Secretary of Health and Human Services.

OIG Comment - Interviews revealed that this continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Even though interviews revealed that the facility has made an effort to recruit and retain nursing staff, there are 42 vacancies currently in nursing staff positions. The facility has been discussing the possibility of developing and implementing a nursing program with a local community college that would include internships and job placement options. During the past three months, the facility has initiated a program of voluntary overtime with a small degree of monetary benefit. Staff interviewed related that voluntary overtime is viewed as separate from mandatory overtime resulting in a member agreeing to do some voluntary overtime then learning that they are expected to work as much as 16 hours of overtime in addition. This finding is ACTIVE.

6 Month Status Report: 07/01/02

The Human Resource Department Central Office, has prepared a notebook of studies and an update of activities to enhance recruitment of nurses at ESH.

1. An In-Band Adjustment for Retention for 37 LPNs, effective 12/10/01 has been approved. This is of varying amounts and aims to bring the LPNs closer to the median salary for LPNs.

2. ESH collected data to support a new hiring range for DSA IIs, which would make ESH more competitive in the labor market. The new hiring range was not approved for use due to fiscal constraints.

3. ESH is reviewing data about RN IIs and wants to develop an In-Band Adjustment for retention.

4. The part time hourly pool of RN IIs has been enlarged and now stands at 18 FTEs. The hourly pool of LPNs has been expanded and now stands at 7.5 FTEs.

5. RNs who retired from ESH are actively recruited to work as WE-14 employees. A program was presented at the ESH Retirees Association and letters were mailed to their homes. Two ESH retirees have returned as part-

time hourly RNs.

6. RNs who resigned from ESH are being recruited to return with some success, i.e. re-employed four returning RNs

7. A revised brochure was mailed to schools of nursing in Virginia to recruit senior nursing students to work at ESH in the summer of 2002.

8. LPNs were placed in continuous recruit in the State Employment system.

9. The Educational Assistance Committee approved several applicants for assistance to attend nursing school; these employees would owe ESH time as an RN when they pass their nursing boards.

10. Retention efforts have focused on assisting nurses to transfer to other programs or units at ESH when there are vacancies and when the employee needs to work with different patients.

11. A referral bonus program has been instituted for RNs, LPNs and DSA IIs. Though available, no bonuses have been awarded to eligible employees for recruiting and referring new nursing staff.

EASTERN STATE HOSPITAL
UNANNOUNCED SNAPSHOT INSPECTION
JULY 9-10, 2001
OIG REPORT # 46-01

Finding 2.2: The facility is considering opening a transitional living program, to be housed in Building 28.

Recommendation: Facility administration must review this plan carefully with the Central Office prior to implementing to determine the legalities, outcome goals and regulatory requirements.

DMHMRSAS Response: Concur. Careful and thoughtful consideration continues to be given to the planned development of the transitional living program in Building 28, which has not be established at this time. The hospital is developing a proposal to be forwarded to the Central Office and the Assistant Commissioner for Facility Management where ramifications for the implementation of such a program will be considered. Any such program must comply with the programmatic curriculum provided within the concept of the Core Services Taxonomy approved by the State Board.

6 Month Status Report: 01/01/02

ESH continues interest in exploring the possibility of establishing a transitional living unit, which they see as a natural expansion of their psychosocial rehabilitation program. They recognize concerns relevant to the Olmstead decision, but believe

there are patients who would benefit from a transitional program increasing their success in community placement.

The General Assembly decision regarding capital funding for renovating buildings for use by their geriatric service will determine the need and use of Building 28. No decision has been made by Central Office at this time regarding the transitional living program.

OIG Comment – Since no decision has been made by the Central Office regarding the feasibility of establishing a transitional living program, this finding remains ACTIVE.

6 Month Status Report: 07/01/02

The General Assembly approved capital funding to renovate Buildings 28, 29 and 30 for geriatric patients. Although ESH may have a continued interest in establishing a transitional living unit, the use of these vacant buildings eliminates a viable location at ESH.

Finding 3.1: The facility ensures that there are adequate numbers of staff present on each of the units.

Recommendation: Maintain staffing levels for effective patient care.

DMHMRSAS Response: Nursing staffing levels are maintained at the hospital utilizing a combination of classified positions, hourly positions, contract staff, and overtime. To the maximum extent possible, given the staffing requirements, voluntary overtime is utilized as opposed to mandatory overtime. A regular financial bonus each pay period was developed and approved for nursing staff that are willing to sign up for this voluntary overtime. A second bonus payment plan was developed for nursing staff that accumulated no unscheduled absences during each pay period. Additional incentives and sign-on bonuses have also been developed to improve recruitment opportunities. During this 2001-2002 academic year, Eastern State Hospital is participating in the SHARPE (named in honor of Bob and Jane Sharpe, who have given funding to the College of William and Mary to support W&M students in working as volunteers to address compelling community needs and public issues enabling students to learn more about themselves, their world, and about the vital importance of using their skills, creativity and knowledge in an overall service to society) Community Partnership Program developed by the College of William and Mary, that is utilizing the Department of Economic to study the nationwide nursing shortage, specifically as it relates to the shortage of Registered Nurses. The goal is to develop additional strategies that include intangible issues such as job satisfaction, dignity and respect in the workplace, and actions that can be taken to improve untoward situations that exist. The possible provision of employer-sponsored childcare for employees is also under continuing study. The hospital also held Nursing Services Open Houses to attract qualified applicants.

6 Month Status Report: 01/01/02
A regular financial bonus each pay period was developed and approved at ESH for nursing staff that are willing to sign up for this voluntary overtime. It is awaiting approval in Central Office. A second bonus payment was developed for nursing staff that accumulated no unscheduled absences during each pay period. This is also awaiting approval in Central Office. No sign on bonus has been developed to improve recruitment opportunities due to fiscal constraints. The additional incentive, which was developed and approved, was a new hiring range for the RN I positions. The hospital held Nursing Services Open Houses on 12/02/00, 03/24/01 and 08/25/01 to attract qualified applicants. The December Open House resulted in the hiring of 3 RNs and 3LPNs. In March, 5 LPNs were recruited and hired. The August Open House netted 1 RN and 4 LPNs. The students from William & Mary College, who are participants of the SHARPE Community Partnership Program, have conducted the survey regarding the Nursing shortage. The data process has been completed, and the students are scheduled to work on a data analysis of this project during the Spring 2002 semester. It is anticipated that the entire project will be completed by May 2002. This possible provision of employer-sponsored childcare for employees is still being discussed at the facility as an incentive.

OIG Comment – Interviews and a review of staffing reports demonstrated that the facility uses a variety of methods to ensure that the numerical staff to patient ratios are met. This is accomplished through the use of overtime, part-time positions and contract employees. Nursing staff related that due to the acuity of the patients that minimum staffing ratios might not provide sufficient resources for the active treatment of patients. This finding is ACTIVE.

6 Month Status Report: 07/01/02
Voluntary overtime continues to be encouraged and is successful. There continues to be the utilization of contract nurses as well as the hourly pool RNs. The hourly pool of RNs was increased. These methods have proven to be successful. The Overtime Bonus Program for nursing staff has been approved and implemented. There is insufficient data to determine whether the program will increase recruitment or retention of nursing staff. The Attendance and Unplanned Leave Program has also been approved and implemented. Again, data is insufficient at this time to determine results or effectiveness. The concept of providing childcare service is still being formulated. However, due to the geriatric center relocation plan, facility space is limited. The three major issues evidenced by the SHARPE Nursing Research Project were 1) the benefits, 2) inadequate staffing and 3) respect. The Facility Director met with the Nursing Director, Medical Director and Human Resource Director to plan intervention for the identified issues. The successful intervention included regular advertisement in the newspaper and meetings with staff who have identified issues related to respect.

Finding 3.2: Staffing shortage is critical for nursing.

Recommendation 3.2 A: There should be a review of current policies and practices for managing overtime to assure equity among staff.

Recommendation 3.2 B: Any new practices should be done with formalized staff input.

DMHMRSAS Response 3.2 A: Nursing staffing levels are maintained at the hospital utilizing a combination of classified positions, hourly positions, contract staff, and overtime. To the maximum extent possible, given the staffing requirements, voluntary overtime is utilized as opposed to mandatory overtime. A regular financial bonus each pay period was developed and approved for nursing staff that are willing to sign up for this voluntary overtime. A second bonus payment plan was developed for nursing staff that accumulated no unscheduled absences during each pay period. Additional incentives and sign-on bonuses have also been developed to improve recruitment opportunities.

6 Month Status Report: 01/01/02
A regular financial bonus each pay period was developed and approved at Eastern State Hospital for nursing staff that are willing to sign up for voluntary overtime as well as a second bonus payment for nursing staff that accumulate no unscheduled absences during each pay period. This has been forwarded to Central Office for approval. There were no sign on bonus developed to improve recruitment opportunities at present. The additional incentive, which was developed and approved, was a new hiring range for RN staff. As an effort to work on the Nursing shortage statewide the DMHMRSAS Central Office is addressing work-force needs through its Workforce Steering Committee, which is headed by the department's Director of Human Resources. The committee met on December 14, 2001 and sponsored a daylong special meeting, Charting the Course, which was attended by advocacy groups, facility and CSB staff, and other stakeholders. Follow-up meetings will be held over the next six months to develop strategies for the state DMHMRSAS system. From these meetings, a formal report with recommendations will be developed and forwarded to the sate Secretary of Health and Human Services.

OIG Comment - Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. This ongoing problem is recognized by the Central Office as a significant statewide issue resulting in the establishment of its workforce steering committee. OIG team members have commented on this issue at ESH during previous visits and notes that despite efforts by the facility to alleviate this problem that it remains a significant source of concern regarding patient care and effective treatment. This finding is ACTIVE.

6 Month Status Report: 07/01/02
Mandatory overtime is utilized as a last option. However, patient and staff safety is the facility's top priority. With an increase in census, efforts were minimized to eliminate mandatory overtime. Staffing needs of units are carefully evaluated to reduce mandatory overtime. The agency has experienced some success with recruitment. The state salaries are not competitive with the private sector, especially with limited funds for annual pay increases. The Nurse Staffing Committee meeting format was changed. Each program's Nurse Manager meets with the nursing staff assigned to the program to problem solve the staffing issues related to coverage. This method allows more autonomy for the Nurse Managers to problem solve the staff shortages utilizing input from the staff involved. (An example of this is, the staff in the admission's program agreeing to pilot the Baylor Plan.) The psychosocial program does alternative scheduling to accommodate staff needs and providing nursing coverage for the units. (An example of this is, allowing staff to work weekends and have other days off during the week.) These are examples of meeting the staffs' needs as well as meeting the nursing coverage for the unit, resulting in a "win", "win" situation.

DMHMRSAS Response 3.2 B: All new recommendations and ideas have been developed through the utilization of a formalized Nurse Staffing Committee, consisting of key management and line staff that have both the knowledge of current conditions and the ability to effect significant and successful change.

6 Month Status Report: 01/01/02
A formalized Nurse Staffing Committee reviews recommendations and ideas to effect significant and successful change. The Committee is examining the impact of the work environment on retention and is promoting a more positive image of Nursing Services throughout the facility. The Committee is also addressing other work related variables including work conditions, workload, and scheduling flexibility. Exit interviews are being reviewed to identify major factors of employee dissatisfaction.

OIG Comment - Interviews revealed that the mandatory use of overtime continues to be a significant problem and the major source of frustration and low morale among the nursing staff. Interviews with management provided additional information regarding the initiatives that the facility has implemented in order to recruit and retain nursing staff with limited result. This ongoing problem is recognized by the Central Office as a significant statewide issue resulting in the establishment of its workforce steering committee. OIG team members have commented on this issue at ESH during previous visits and notes that despite efforts by the facility to alleviate this problem that it remains a significant source of concern regarding patient care and effective treatment. This finding is ACTIVE.

6 Month Status Report: 07/01/02
Nurse staffing committee meetings have been conducted within the buildings showing the highest use of mandatory overtime. Additional improvement is being made. This involves more evenly distributing staff across the shifts, and increased utilization of 12 and 16-hour shifts, where preferred. In addition to this, other alternative strategies are being considered, i.e. some staff prefers working more weekends than weekdays. The staff morale is currently of high priority for nurse management, with feedback from the clinical nursing staff. Where possible, interventions for corrections are being put in place. Mandatory overtime is currently under consideration by the American Nurse's Association. ESH has expanded Internet posting of jobs. The Admission's Unit will pilot the Baylor Plan for one (1) year and then evaluate the use of this plan. The Baylor Plan provides Eastern State Hospital with the ability to offer a scheduling option to attract and retain Registered Nurses to work weekends. All Registered Nurse II positions are designated to be used for the Baylor Plan. Registered Nurses (RNIIs) on the Baylor Plan will work three (3) 12-hour shifts over their scheduled weekend – Friday, Saturday, Sunday or Saturday, Sunday, Monday. For the 36 hours worked they will be paid for 40 hours and receive full state benefits.

EASTERN STATE HOSPITAL
SNAPSHOT INSPECTION
JANUARY 9-10, 2002
OIG REPORT # 53-02

Finding 1.1: Overall the physical environment of the Hancock Center was clean and comfortable, with evidence that effort has been made to decrease the institutional appearance.

Recommendation: Continue to promote efforts that result in softening and personalization of this harsh institutional setting.

DMHMRSAS Response: Eastern State Hospital will continue its ongoing efforts to personalize and promote a home-like environment. Purchasing, in collaboration with Clinical Leadership in Hancock Geriatric Treatment Center, continues by shopping catalogs for safe and appropriate accessories and decorations for the Geriatric clients.

6 Month Status Report: 07/01/02
Eastern State Hospital continues to enhance the therapeutic environment for geriatric patients. (Renovations to Building 28, 29, & 30 along with planned construction of a new geriatric activity building (Building 31), and the subsequent move of all patients from the Hancock Center must be considered when planning additional changes within the existing buildings in Hancock.) Requirements for the renovated facilities are currently being identified and consolidated for a funding request to the 2003 session of

the Virginia General Assembly that will represent the balance of dollars that will be necessary to complete the geriatric relocation project.

Finding 2.1: The GAP (Geri-Active Program) is designed to meet the active treatment needs of the higher functioning geriatric patient.

Recommendation: The GAP program offers a variety of active treatment options for the minority of higher functioning geriatric patients. Administrative and clinical leaders must seriously re-evaluate the mission and model for active treatment for the remaining geriatric population at ESH.

DMHMRSAS Response: ESH HGTC's Interdisciplinary treatment teams will continue to assess patients' needs and functional level and develop specific treatment and care plans to address those needs and limitations. Additionally, monthly the GAP subcommittee will review current schedules, program descriptions, staff assignments, and patient participation data and make recommendations to HGTC Clinical Leadership to enhance patient interventions for all functional levels, to provide clarification to the Inspector General. GAP is the overall description of scheduled groups and activities for patients in geriatric services. IGAP is the "step-up" program for the 40-50 higher functioning patients in geriatrics.

6 Month Status Report: 07/01/02
Eastern State Hospital HGTC Clinical Leadership Team continues to emphasize to treatment teams and each discipline the need to ensure that all patients are receiving active treatment based upon their needs and functional levels. The GAP Subcommittee is charged with reviewing program schedules, patient related data, and staff assignments for optimum use of resources.

Finding 2.2: Active therapeutic treatment options for lower functioning geriatric patients were minimal.

Recommendation: A review of active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

DMHMRSAS Response: The Clinical Leadership in Hancock Geriatrics Treatment Center and all discipline supervisors will ensure groups/activities are conducted according to the schedule, according to group objectives, and content as outlined in the specific program descriptions and based upon the patients' interests and needs. Monitoring of the process will be accomplished daily utilizing the Visual Patient Contact Application (VPCA). This is a computerized system, which measures time spent with patients related to structured treatment activities. Supervisors will review patient participation to identify patients who may be underserved through the group process and who may benefit from more individualized attention. The GAP subcommittee will oversee and coordinate these efforts through its monthly meetings and findings will be reported to clinical leadership.

6 Month Status Report: 07/01/02
Eastern State Hospital HGTC Clinical Leadership Team has developed a more comprehensive and complete review of active treatment activities with and for the lower functioning geriatric patients. Staff education is planned to increase staff's knowledge and ability to articulate the daily active treatment that is occurring.

Finding 2.3: Late afternoon and early evening activities in Building 34 were not taking place as scheduled.

Recommendation: A review of the active treatment activities for lower functioning patients is warranted in order to provide effective and appropriate options for this population.

DMHMRSAS Response: The Clinical Leadership in Hancock Geriatric Treatment Center will assess afternoon and evening patient care needs and routines. They will communicate the schedule and expectations to all staff. The treatment teams will identify relevant active treatment interventions for individual patients to improve function, or reduce loss of function. The estimated completion date for assessing the needs and identifying the interventions is May 31, 2002. Current scheduled GAP groups end by 3:00 p.m. Evening programming, when scheduled, begins at 6:00 p.m.

6 Month Status Report: 07/01/02
Ongoing the facility does a complete review of the overall program and patients' daily schedule by the Clinical Leadership Team and GAP Subcommittee. This ensures that programs are occurring as scheduled and not conflict with individual patient care related activities. A Master Schedule revision is currently being developed for implementation in July 2002.

Finding 2.4: Records reviewed reflected limited documentation linking treatment needs to discharge readiness and the justification for continued hospitalization.

Recommendation: Promote better utilization of the clinical talent participating in the treatment planning conferences. Improve concentration by the teams on issues related to preparation of patients for discharge, as evidenced in the records.

DMHMRSAS Response: To promote improved utilization of the clinical staff's participation in treatment planning conferences, the HGTC program is implementing a computerized treatment planning system (Vista Care), which will reduce the overemphasis on the completion of forms. Vista Care requires the development of plans for particular patients based on triggered areas of the MDS (minimum data sets). This would be beneficial to both higher and lower functioning patient groups. In addition, the recently implemented use of the "Needs upon Discharge" form will not only add to the consolidation and streamlining of paperwork, but will better focus the team's efforts on resolving discharge barriers in a more expedited fashion.

6 Month Status Report: 07/01/02
The program implemented was incorrectly identified as Vista Care when in fact, it is the VistaKeane System. As of June 13, 2002 the percentages of care plans entered into the VistaKeane System are: Building 4: 100% completed; Building 32: 95% completed; Building 34: 25% completed; Building 36: 100% completed Average HGTC/Medical Services: 80% completed {164 out of 206 completed} Building 32 will be 100% complete by June 28th. Building 34 will maintain its 2 plans per week implementation process. It is envisioned that by training more RNs (8) in computerized care plans, the efforts of MIS (new hardware and improved computer lines throughout HGTC) and patient transfers from B-32 with computerized care plans, all patient care plans will be computerized in HGTC. Estimated completion date for computerization of all plans is October 1, 2002.

Finding 3.1: Staffing shortages are critical for nursing services in the Hancock Center.

Recommendation: Administrative and clinical leaders must seriously re-evaluate the mission and model for the goals of serving the geriatric population. Increase staffing levels as needed for active, effective patient treatment rather than basic patient care if this is determined to be the treatment goal for the Hancock Center.

DMHMRSAS Response: The assessment of the recruitment and retention of nursing staff is ongoing. Recruitment of nursing staff in Hancock Geriatric Treatment Center (HGTC) is difficult, in part, due to the required physical work involved with geriatric population. However, the staff that work in this area desire to do so. Through contract nursing staff are utilized, few of them desire to work with the geriatric patients. The above conditions often contribute to the need for mandatory overtime. There is a system in place for this and has been reviewed with the nursing staff. There is a mandatory overtime list, however, voluntary overtime is utilized first as well as hourly and contract staff. When these options are not possible, mandatory overtime is required. Once the nurse works overtime, his/her name goes to the bottom of the list.

Despite the above issues, the Nursing Department continues to recruit and retain nursing staff with strong support from our Human Resources Department. Since December 2001, we have hired eight (8) DSA's and one (1) LPN for duty in geriatrics. Additionally, two (2) Registered Nurses have been offered positions. Recruitment and retention is ongoing at ESH.

6 Month Status Report: 07/01/02
Voluntary overtime continues to be encouraged and has been successful. There continues to be the utilization of contract nurses as well as the hourly pool RNs. The hourly pool of RNs was increased. This method continues to be utilized with some success.

NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
RESPONSE TO SNAPSHOT INSPECTION
NOVEMBER 9, 2001
OIG REPORT #49-01

Finding 3.2: Discharge planning continues to be a significant challenge for this facility.

Recommendation: Continue to strive for successful linkages for all patients at the time of discharge.

DMHMRSAS Response: DMHMRSAS concurs. The discharge planning process at NVMHI has been in place for 14 months since revision in November 2000. Performance monitoring continues to show sustained improvement, scoring above threshold for the past 5 monitoring periods. Monitoring of the discharge planning process continues to show strong integration between the CSBs and the treatment teams. CSB Aftercare workers continue to demonstrate a consistent presence at CTPs, TPRs, weekly meetings with patients, and family meetings.

In late December 2001, an educational program on "Discharge Protocols for CSBs and State Mental Health Facilities" was presented by DMHMRSAS staff. New Departmental Discharge Protocols were reviewed to ensure standardization of the process across facilities. Two sessions were conducted and 59 staff were in attendance, including: psychiatrists; psychologists; nurses; social workers; CSB Aftercare workers; utilization management staff; and the patient advocate.

6 Month Status Report: 07/01/02
NVMHI has developed and published an updated discharge planning policy to implement the statewide "Discharge Protocols for Community Services Boards and State Mental Health Facilities". The CSBs are committed to successfully implementing both the state performance contract and the "Discharge Protocols for Community Services Boards and State Mental Health Facilities". Both of these documents directly address the need for consistent direction and coordination of those activities that result in the successful linkages for all patients at the time of discharge. The results of the newly developed NVMHI Discharge Planning Quality Monitor have exceeded the 90% threshold during the first two months of monitoring. This data demonstrates that there continues to be successful linkages for all patients at the time of discharge, as evidenced by the strong integration between the CSBs and the NVMHI treatment teams.

NORTHERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION
SEPTEMBER 9-11, 2001
OIG REPORT # 48-01

Finding 1.2: The advocate at NVTC addresses issues relevant to human rights through monitoring, training and contact with residents and staff.

Recommendation 1.2a: Continue to support the advocate's visible presence for staff and residents in order to maximize awareness regarding issues relevant to abuse and neglect.

DMHMRSAS Response: The NVTC administration continues to support the advocate's presence to maximize staff and resident awareness regarding issues relevant to human rights, abuse and neglect. They recognize that visibility and availability are key to a good human rights advocacy system. The new Department Human Rights Regulations include a new informal complaint process that empowers the facility to address easily resolved complaints without involving the human rights advocate. If such a complaint cannot be resolved within five days, then the advocate must be notified. This process will provide for some complaints to be resolved in a more timely manner by the treatment team, unit staff or others and will provide for increased opportunity for the advocate to address more serious or high risk human rights issues such as abuse and neglect. The advocate will continue to provide a visible presence for staff and residents relevant to human rights.

6 Month Status Report: 01/01/02
The NVTC administration continues to support the advocate in her duties. The NVTC Director and the advocate are working together to redefine reporting requirements pursuant to the Department of Human Rights Regulations promulgated on 11/22/01. Training in the regulations and the new informal complaint process will be provided to NVTC staff throughout this coming year, 2002.

***OIG Response**: Interviews revealed confusion regarding the timeframe of implementation and training of the new Human Rights regulations. This finding rema*ins *ACTIVE.*

6 Month Status Report: 07/01/02
Training in the Human rights regulations promulgated on November 22, 2001 has been, and continues to be, as follows: • Effective 7/1/02, the Human Rights training will be conducted by the NVTC Social Work Department. • Designated clinical staff attended local training on the new regulations in May 2002. We have requested a videotape of that session for future use, if necessary. • The NVTC Advocate scheduled unit-based in-services for current employees during the month of April 2002. Attendance at these sessions has been taken and submitted to the Training Department. • All NVTC clinical management staff attended training on the new regulations in December 2001 provided by the Office of the Attorney General and the Office of Human Rights. We have requested a videotape of that session for future use, if necessary. • New employee training: The curriculum was modified to include the new regulations in February 2002. The NVTC Advocate has conducted this training to date. Effective July 2002, a Social Worker will present Human Rights

training.

- Current employee training: Annual Re-training is conducted once a month; staff are scheduled to attend during their "hire month". Therefore, training of all current staff, hired prior to February 2002, will be completed by March 2003. Information on the new regulations has been included in the Human Rights annual retraining session since March 2002. The NVTC Advocate has conducted this training to date. Effective July 2002, a Social Worker will present Human Rights training.
- The State is developing a videotape/workbook training program for all staff. This will have vignettes and exercises to help convey the information.
- The NVTC Director's Office has publicized and distributed the facility policy on informal complaints to all employees. All units have a copy of the revised Human Rights Regulations. A memo dated June 20, 2002 explaining the new complaint process was sent to all NVTC employees and all client Authorized Representatives. In addition, a flyer that contains a simple flow chart of the new process accompanied that memo. This flyer has been posted on all client living units. These written materials will serve as another training method to ensure that staff have current information on the Human Rights regulations.
- The NVTC policies have been revised and reviewed by the facility Advocate, who determined that these policies met the requirements for compliance with the new Human Rights Regulations by July 1, 2002.

Recommendation 1.2b: The OIG will coordinate a meeting with the State Human Rights Director to review the new changes, the purpose for these changes and the impact these may have on the consumers.

DMHMRSAS Response: The Commissioner welcomes the opportunity for the Inspector General to meet with the Director of Human Rights and specific DMHMRSAS management staff, and will seek to establish such a meeting in the near future to review the changes to the Human Rights Regulations and the impact the changes may have on consumers.

6 Month Status Report: 01/01/02
The Central Office and the Human Rights Director will welcome a meeting with the Inspector General to discuss impact of new regulations on consumers.

OIG Response – *The OIG will work to coordinate a meeting with the state Human Rights director to discuss the impact of the shift in facility advocate focus from the facility to a community setting. This finding is ACTIVE.*

6 Month Status Report: 07/01/02
The Central Office and the Human Rights Director continue to welcome a meeting with the Inspector General to discuss the regulations.

Finding 1.3: The Facility Risk Manager also functions as the Quality Assurance Director, and serves as the facility Abuse and Neglect Investigator.

Recommendation: The facility needs to review with the Central Office the nature of these functions with serious consideration given to the separation of each of these three tasks to assure that the protection of the residents are foremost.

DMHMRSAS Response: It is anticipated that in the next several months, DMHMRSAS will be centralizing all abuse/neglect positions to assure that Abuse/Neglect investigations are not undertaken by persons serving multiple and/or conflicting roles in the facility. They will serve and be trained in the singular function of Abuse/Neglect Investigations.

At present, two different NVTC staff are responsible for the risk management function and the quality assurance function. However, one of these persons has supervisory responsibility over both functions. The Director of NVTC will review the supervisory function performed by the Risk Manager relative to the Quality Assurance staff to determine if this role is a conflict of interest. A decision will be made by December 31, 2001 and forwarded to the Central Office for review.

6 Month Status Report: 01/01/02
DMHMRSAS will be centralizing all abuse/neglect investigations to assure that persons serving multiple and/or conflicting roles do not undertake such investigations. NVTC continues to maintain a Risk Manager with supervisory authority over the Quality Assurance manager. The Risk Manager reports directly to the NVTC Director. The NVTC Director reviewed the supervisory relationship of the Risk Manager relative to the Quality Assurance manager and determined that Risk Management is a key part of the organizations dedication to improved performance, safety, efficiency and productivity. Although the NVTC risk manager is supervising the functions of the quality assurance manager the two staff work in tandem to integrate quality control management and quality assurance. The two positions work closely to assess the various types of risks that exist across the center and to identify strategic control and improvement plans. The quality assurance manager reports on the quality of care to the clients, the systems to improve performance and the protections in place to protect individuals. The Director of NVTC requires the relationship between the two positions to continue in the complimentary fashion with which they have existed.

OIG Response**: Interviews demonstrated that the facility continues to use the risk manager in the role of the primary abuse investigator. The facility provided a copy draft DI 201, which outlines proposed changes in the investigative process. This finding remains **ACTIVE.

6 Month Status Report: 07/01/02
Until such time as the DMHMRSAS proposed centralization of all abuse/neglect investigations occurs, the NVTC Risk Manager continues to function as the primary abuse investigator. However, during any Abuse/Neglect Investigation, the Risk

Manager is directly accountable to the Central Office Manager of Abuse/Neglect Investigations during the entire investigation process, and not to facility management. The Central Office Abuse/Neglect Investigation Manager supervises the process until a thorough and complete investigation is concluded.

In recent months, due to staff turnover, NVTC has been reduced to two certified investigators at the center. To address the need for additional investigators, NVTC will select candidates from existing staff to obtain the next statewide Investigation Certification Training, which is planned for October of 2002. NVTC will enroll at least one staff member to become a certified investigator; and additional staff may attend depending on the availability of openings at the training. As more NVTC staff are certified to investigate allegations of abuse/neglect, the Risk Manager can delegate the investigations, thereby reducing the dual role.

Finding 3.2: The facility has an established nutritional management program.

Recommendation: Review nutritional management plans for all residents to assure that dates reflect the most current assessment.

DMHMRSAS Response: It should be noted that what is referred to in the OIG's report as the Nutrition Management Plan is called the mealtime guidelines at NVTC. The Nutrition Management Plan at NVTC is actually a separate document that has recommendations from the nutrition management team. All mealtime guidelines are reviewed annually and amended as needed.

Considerable care has been taken to disseminate revised mealtime guidelines throughout the system so that each staff who deals with the client has the correct mealtime information. For example, the mealtime guidelines are located in at least two places on the unit (in a holder for display and in a Program notebook for back up), in the client's CRS, in the Client Records (original), in the Instructional Kitchen for recreational use, at the worksite, in the master notebooks in Occupation Therapy Department (OT), and on the shared computer "O" drive for retrieval, should the client need to be hospitalized. The information is also placed in the Client Data Base, where reports can be generated for use at special events.

In order to ensure that all the mealtime guidelines are up to date as of 11/1/01, the Occupation Therapy Department is comparing the guidelines on all the units to the master document in the OT Department. This review will be completed by 11/15/01. OT will change the Individual Habilitation Plan (IHP) and OT Comprehensive Evaluation formats to ensure that the annual review date of mealtime guidelines is explicitly stated and easily located. The revised evaluation format will be initiated on 11/1/01. To conform to the IHP schedule, this change will be reflected on each OT Comprehensive Evaluation format by 10/31/02. The annual review date of mealtime guidelines will be located in the OT IHP summary section that is incorporated into each client's annual IHP report by the unit social worker.

As an ongoing quality assessment measure, the OT Department will initiate a quarterly survey of the unit dining room mealtime guidelines to ensure that they are the most recent versions. Given the above comprehensive review and to conform to the NVTC Continuous Improvement Plan

(CIP), the first quarterly review will be completed in April 2002. A survey of OT IHP reports will also be done quarterly to ensure that therapists are documenting the mealtime guidelines review. This information will be reported as part of the OT Department's CIP to be initiated this year October 1, 2001.

6 Month Status Report: 01/01/02
The Occupational Therapy department completed the audit of all mealtime guidelines on display in the unit dining rooms on 10/26/01. The audit revealed discrepancies in the mealtime guidelines for 30 clients. These discrepancies were corrected immediately. In addition, OT has made the following modifications to the mealtime guidelines process: **1.** The Individual Habilitation Plan (IHP) and OT Comprehensive Evaluation formats were revised to ensure that the annual review of mealtime guidelines is explicitly stated and easily located. This revision was initiated on 12/1/01 and will be completed as per the IHP schedule by 11/30/02. **2.** The annual review of mealtime guidelines will be located in the OT IHP summary section that is incorporated into each client's annual IHP report by the unit social worker. **3.** The mealtime guideline form has been changed to document the date initiated. **4.** As an ongoing quality assessment measure, the OT Department will perform a quarterly survey of the unit dining room mealtime guidelines to ensure that they are the most recent versions. The first quarterly review will be completed in April 2002. **5.** OT will coordinate the filing of the mealtime guidelines with the assistance of Client Records

OIG Response - *Interviews and review of documentation indicated that the facility is in the process of updating their nutritional management plans. Tours demonstrated there has been a current review of the plan and that staff were conducting meals in accordance of the prescribed guidelines for each resident. Supervisory staff indicated that the phase in process of the plans was occurring and has not been completed. This finding remains* ***ACTIVE.***

6 Month Status Report: 07/01/02
The NVTC Occupational Therapy Department continues to update the nutritional management plans as defined in the process detailed above. As planned, the total phase in process will be completed November 30, 2002.

Finding 3.4: Annual individualized program plans (IPP) as constructed were based on professional assessments and a review of objective and supported observational data by an interdisciplinary team.

Recommendation: Enhanced documentation regarding identified problems, which are noted outside of the formalized annual process by including them on the problem list; outline the plan of action and justification for interventions.

DMHMRSAS Response: NVTC has a Standing Client's Records Committee to improve center wide issues related to documentation of problems and issues. At the IHP meetings, problems and supports are identified. Problems and issues are regularly reviewed at the NVTC clinical meetings. The responsible staff carefully tracks formal programming and documents the status in the client record. The Clinical Management Meeting minutes detail discussions concerning formal programming and other various issues requiring action. By December 1, 2001, the Client's Records Committee will review the problem identification process, the means by which problems and issues are tracked and make recommendations. Currently, the Client Records Department audits individual client records two months after the IHP. Qualified Mental Retardation Professional (QMRP) reviews are conducted quarterly on all formal programs. In addition, Inspection of Care audits are completed twice a year for each individual client record. These audit processes ensure that progress (or lack of progress) for any problem is tracked.

Current coordinated efforts between Client Records and the Interdisciplinary Teams to incorporate the problems list into the client database will contribute to the overall goal of an improved process.

6 Month Status Report: 01/01/02
The Standing Client's Records Committee met on 11/27/01. The problem list has been revised and the process improved to assure that identified problems that are noted outside of the formalized annual process are included on the problem list. Problem lists are updated throughout the year to include new problems. The Client Records Department audits of individual client records and QMRP quarterly reviews will ensure coordination between the problem list, plan of action and justification for interventions.

OIG Response *– During this follow-up we tracked the response of the facility in one of the cases that created the original finding and determined that the process continues to allow an event in which multiple interventions are occurring on behalf of a resident without being noted as problem. In the case referred to, staff identified that the behaviors associated with a life health safety concern but even at this level could be viewed as an issue and not a problem. This finding is ACTIVE.*

6 Month Status Report: 07/01/02
Following the Inspector General's visit, the NVTC Social Work Department held a meeting to discuss the need for increased clarity and 'flow' regarding client interventions within the clinical notes of the client record. The Social Workers as QMRPs went back to all ID teams to discuss fragmented or difficult to follow documentation and the need for increased clarity and 'flow' within the clinical notes. The ID Teams will continue to document all of the actions, supports and concerns in the bi-weekly minutes for the Clinical Meetings. The Director of Social Work will monitor the quality of the documentation of unresolved clinical issues from meeting to meeting on an ongoing basis with each ID Team. Regular documentation of the issues assures that issues will be discussed and resolved to the best benefit of the client, regardless of any current change of status.

There are differences in documentation for client problems versus issues. At the Inter-disciplinary Team level, both problems and issues are concerns with potential affects to the well-being and quality of life of the clients. To clarify the difference between a problem and an issue, the following working definitions are provided:

A problem is an indication of an identified training need for the client. Most often a problem is addressed through a formal active treatment/training program. Problems are registered in the IHP and are frequently changed throughout the year. Changes in the IHP occur as the responsible clinician presents updates, and the team has clinically assessed the need for a change.

Issues are concerns that do not require a formal active treatment/training program. Because there is no specific client training involved, there is no formal problem number assigned. These concerns are addressed through staff actions and clinical assistance. These issues and the staff actions and clinical assistance accomplished are documented in the client's record. IDT discussion of those efforts will also be documented in the bi-weekly clinical minutes.

NVTC Interdisciplinary Teams (IDT) convene at clinical meetings every two weeks to assure clinical follow up and review. Their purpose is to guarantee that the client's needs are met and that nothing is left unresolved for long periods of time in the area of client care. If, in the course of the IDT discussion, a need for active treatment/ training is identified for a client, the problem is added to the problem list, and the program is initiated.

There are certain times when multiple interventions are occurring for client issues. In such instances, the ID Team has concluded that there is no teaching goal to be addressed. Ongoing staff and clinical involvement occurs to explore and address the issue as well as provide support to the client.

Finding 4.3: During the initial evening visit, staff were lax in identifying team members and ascertaining the reason for the team's presence, compromising facility security.

Recommendation 4.3b: Retrain staff as to current expectations regarding unknown person being present at the facility.

DMHMRSAS Response: The visitor policy is being reviewed, and campus wide re-training is underway regarding the responsibilities of NVTC employees when visitors are on campus for official state business as well as addressing all unannounced unofficial visitors to the unit who are unfamiliar to the facility.

In addition, the NVTC Master Plan for 2001 recommends potential security options. Immediately, appropriate actions will be initiated to improve communication between the roving team leader, security and the residences on campus. The NVTC administration is exploring several additional options for increased security, such as:

- Immediate review of any future security breach by the Risk Manager
- A sign-in policy at each residence with the possibility of requiring non-familial visitors or employees to wear identification badges
- Publicly posting a visitor procedure at the entrance to each building.

A decision will be made by November 31, 2001 and forwarded to the Central Office for review.

6 Month Status Report: 01/01/02
The status report was sent to Central Office on November 30, 2001 concerning retraining of staff regarding unknown persons being present at the facility. The visitor policy has been reviewed, revised and approved effective December 14, 2001. The NVTC Director issued correspondence to the families and guardians explaining the revised visitor policy on December 20, 2001. Campus wide re-training regarding the responsibilities of NVTC employees concerning unannounced official and unofficial visitors was concluded on November 9th. On November 26th program managers were reminded to once again review the visitor policy with their staff. As of December 20th, 2001 visitor check-in procedures are displayed at the entrances to each of the units. Sign-in sheets for visitors are located in the team station. Additionally, the NVTC administration is preparing to require all employees and non-familial visitors to wear an NVTC identification badge. This practice will be in place by February 1, 2002. NVTC administration is working on the following tasks to implement this requirement: • Assess the different types of identification badge clips and break away neckwear. • Order and stock sufficient quantity of badge clips and visitor badges for non-NVTC employees. • Inform NVTC employees of the initiation of this requirement. • Develop permanent visitor policy sign and periodically reassess display locations. • Implement sign-in sheets and assess efficacy of this new practice.

OIG Response – *Tours demonstrated that there were signs posted directing visitors to sign in at team stations and that sign in sheets and visitor tags were required. During the after hours tour inconsistencies in the application of the visitor policy were noted. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
NVTC has modified the process of issuing visitor passes to reduce some of the inconsistencies. The visitor passes will be color coded, i.e. visitors to residential services will have blue tags, visitors to training will have lime tags, etc.). Additionally all of the visitor tags will contain the same information, specifically, the name of the department the person is visiting, the date of the visit and the name of the visitor. Should a visitor fail to discard or return a visitor pass upon conclusion of the visit the date of the authorized visit will be on the tag. As a result, unauthorized attempts to enter other areas and return on other dates will be more easily detected by the badge color and

date on the badge. NVTC staff will continue to address inconsistencies in the implementation of this policy as the need arises.

Finding 4.4: Efforts at making this institutional setting appear more "home-like" were viable.

Recommendation: Broaden the effort to enhance the physical living environments for all NVTC residents

DMHMRSAS Response: Each residence at NVTC has an ambiance budget. As part of the 2002 Continuous Improvement Plan (CIP), each residence will provide a plan to enhance the home-like appearance of each unit. NVTC will tap the talents of artistic and creative staff and families to gather ideas to improve the appearance of the residences. In addition, the NVTC Volunteer Services Department is soliciting assistance from decorators, designers and the local college interior design students to garner recommendations and suggestions to make the living environments more home-like by December 31, 2001.

6 Month Status Report: 01/01/02
The Public Relations and Community Development Office has solicited local interior decorators, investigated web sites and contacted area universities to obtain interior design consultation. The Interior Design internship coordinator at Marymount University has expressed an interest in working with NVTC on this project. NVTC will pursue this relationship to enhance the décor on the units and will continue to pursue other resources. Occupational Therapy will consult with design staff to enhance client function and safety in proposed environmental changes.

OIG Response – *Interviews have demonstrated that the facility has made efforts to contact local universities to engage an interior design intern. This finding is* ***ACTIVE.***

6 Month Status Report: 07/01/02
The contacts with the local universities have been inconsistent due to staff turnover in NVTC's Public Relations and Community Development Office. NVTC will continue to make efforts to improve the client environment.

Finding 5.3: The NVTC Psychiatrist has developed a mechanism for the tracking of individuals who are on more than one psychotropic medication.

Recommendation 5.3b: Consideration should be given toward convening a meeting of psychiatrists employed by training centers in Virginia to understand the wide variability in use of different types of medications for a similar clinical population.

DMHMRSAS Response: Preliminary meetings of this nature are already underway in the through DMHMRSAS. The state has contracted with Dr. Ruth Ryan to assist with the dissemination of information regarding psychiatric treatment and the use of psychotropic

medications for people with mental retardation. A presentation entitled "One Day Intensive Course with Ruth M. Ryan, MD: Mind, Body and Soul: Psychiatry for Persons with Developmental Disabilities" is scheduled for December 4, 2001.

The DMHMRSAS Medical Director has convened a meeting of the Medical Directors of the Training Centers to develop a guideline for making psychiatric diagnoses at the Training Centers by February 2002. Considerations will include "presumptive diagnoses", "provisional diagnoses", and perpetuation of the use of "rule outs".

6 Month Status Report: 01/01/02
Dr. Ruth Ryan, a national expert and consultant to the Department, provided a three-day Poly-Conference, "Mind, Body, Soul: Psychiatry for Persons with Developmental Disabilities". All Medical Directors and medical staff of training centers were encouraged to attend. In early Spring 2002, a poly-com meeting will be held with training center psychiatrists and the Medical Director to further explore improvements made in this area.

OIG Comment – *The OIG has not been made aware of the date and time that the meeting occurred with Training Center psychiatrists. This finding is ACTIVE.*

6 Month Status Report: 07/01/02
There are practical impediments to convening a meeting of training center psychiatrists. These psychiatrists are almost all part-time, attend the training centers at different times and days, and have other professional activities that would preclude their attending a meeting that for many would require allotting a full day. The planned alternative is to arrange a poly-com session, where at least most of the psychiatrists, and all the relevant clinical training center staff, including medical directors, could 'attend'. Arrangements for a poly-com meeting have been initiated. The Medical Director for the Office of Health and Quality Care has asked the NVTC psychiatrist if he would be willing to make a presentation, or series of presentations, on this subject.

Finding 8.1: NVTC maintains a culturally diverse staff.

Recommendation: This is an issue for many employers in northern Virginia area including Northern Virginia Mental Health Institute. Perhaps consultation with professional human resource managers could enhance the ability of NVTC to engage and promote staff of different cultures as well as develop awareness and sophistication of supervisory staff at NVTC in working with employees of many different cultures.

DMHMRSAS Response: The NVTC Human Resources Department, the Staff Training and Development Department and the Director of Residential Services have been meeting for the past three months to examine the issues of recruiting, interviewing and training a culturally diverse work force. Some of the issues identified include: English as a second language, reading comprehension and writing skills, and cultural issues related to client care and treatment. The

identification of issues and possible means of address is in the infancy stages and a number of possible options to effectively address issues are being investigated. The Director of Human Resources and the Director of Staff Training and Development are researching appropriate tools to add to the training curriculum for supervisors to build management skills to address a culturally diverse work force.

6 Month Status Report: 01/01/02
The NVTC staff continue to pursue a comprehensive approach to diversity issues in the work force as described above. In addition, the Director of Human Resources, the Director of Training, the Director of Residential services and the Director of Clinical Services attended the workforce summit steering committee on December 14, 2001 at the University of Richmond. The Director of Training has obtained a training program on cultural diversity from the University of Minnesota Institute on Community Integration and the National Alliance for Direct Support Professionals. This package is being reviewed.

OIG Comment – *Interviews indicated that NVTC has made efforts to address diversity issues. At the time of the follow-up, it was learned that the facility was obtaining a training program for review regarding this topic. As the facility is still in the process of reviewing ways of addressing this concern, this finding remains ACTIVE.*

6 Month Status Report: 07/01/02
The training director at NVTC has modified the curriculum to meet the specific needs of the supervisors at NVTC. To further enhance staff training, the NVTC Training Director also has completed development of an Instructor Guide, a Student workbook and a Microsoft Power Point presentation.

NORTHERN VIRGINIA TRAINING CENTER
RESPONSE TO SNAPSHOT INSPECTION
FEBRUARY 25, 2002
OIG REPORT # 55-02

Finding 2.1: There is inconsistent information regarding the projected completion of the new human rights regulations training for direct care staff.

Recommendation: The new human rights regulations served as an important framework for assuring that residents are treated with dignity and respect free from neglect, abuse and exploitation. As staff are held accountable to the regulations, timely training is imperative. Facility staff in conjunction with the Central Office needs to establish a timeframe for the successful completion of this important training.

DMHMRSAS Response: The Department's Office of Human Rights (OHR) has provided training to specific NVTC staff on two occasions: at a site visit on December 13, 2001 and via poly-com (along with other facilities) on February 7, 2002. At those

times, NVTC administrators, program managers and clinical staff participated in the training. The OHR also is developing videotapes of those trainings for use by all facility administrators, program managers and clinical staff for training. NVTC requested copies of those tapes in March 2002.

In addition, five comprehensive OHR training sessions, to be made available to all staff, are scheduled at various sites on a regional basis and will be videotaped. Videos of those five trainings will be available to the facilities by request. This OHR training process will be completed by June 30, 2002.

The Office of Human Rights is also assisting the training directors in developing competence-based training materials. The projected completion date is June 30, 2002.

The NVTC Advocate will continue to train new staff during pre-service and current staff in annual re-training. In addition, the Advocate has begun providing unit-based training to residential staff across all shifts. The NVTC Executive Director will continue to work with his training staff and the Advocate to expedite training to all direct care staff.

6 Month Status Report: 07/01/02

Training in the Human rights regulations promulgated on November 22, 2001 has been and continues as follows:

- Effective 7/1/02, the Human Rights training will be conducted by the NVTC Social Work Department.
- Designated clinical staff attended local training on the new regulations in May 2002. We have requested a videotape of that session for future use, if necessary.
- The NVTC Advocate scheduled unit-based in-services for current employees during the month of April 2002. Attendance at these sessions has been taken and submitted to the Training Department.
- All NVTC clinical management staff attended training on the new regulations in December 2001 provided by the Office of the Attorney General and the Office of Human Rights. We have requested a videotape of that session for future use, if necessary.
- New employee training: The curriculum was modified to include the new regulations in February 2002. The NVTC Advocate has conducted this training to date. Effective July 2002, a Social Worker will present Human Rights training.
- Current employee training: Annual Retraining is conducted once a month; staff are scheduled to attend during their "hire month". Therefore, training of all current staff, hired prior to February 2002, will be completed by March 2003. Information on the new regulations has been included in the Human Rights annual retraining session since March 2002. The NVTC Advocate has conducted this training to date. Effective July 2002, a Social Worker will present Human Rights training.
- The State is developing a videotape/workbook training program for all staff. This will have vignettes and exercises to help convey the information.
- The NVTC Director's Office has publicized and distributed the facility policy on informal complaints to all employees. All units have a copy of the revised Human

Rights Regulations. A memo dated June 20, 2002 explaining the new complaint process was sent to all NVTC employees and all clients' Authorized Representatives. In addition, a flyer that contains a simple flow chart of the new process accompanied that memo. This flyer has been posted on all client living units. These written materials will serve as another training method to ensure that staff have current information on the Human Rights regulations.

- The NVTC policies have been revised and reviewed by the facility Advocate, who determined that these policies met the requirements for compliance with the new Human Rights Regulations by July 1, 2002.

Finding 3.1: The evening activities observed were designed for the basic care and meeting daily living activities of the residents.

Recommendation: Continue to assess the needs of each client and offer appropriate activities to meet those needs.

DMHMRSAS Response: NVTC continues to assess the needs of each client through the interdisciplinary team meetings and the ongoing bi-monthly clinical reviews. NVTC active treatment data is summarized by quality assurance and reviewed by senior staff, program managers, and clinical supervisors monthly.

In addition, Residential Services assesses active treatment through the use of the active treatment monitoring tool. This tool reviews the dynamics of active treatment such as: client and staff interaction, the adequacy of supplies and equipment for programming and client-to-client interactions; this tool also assesses consistency between what is written in the Individual Habilitation Plan (IHP) with what takes place during the hours of active treatment. The data generated through the use of this tool has been valuable to the Program Managers, team leaders, and clinicians who have been using it with increased frequency to assess active treatment and to guide management decisions.

6 Month Status Report: 07/01/02

The NVTC teams assemble at least every two weeks to review client progress, discuss needs and review activities. Clinical meetings convene to assure clinical follow up and review. The clinical meeting outcome is to review the client's needs and to establish that no issues remain unresolved for long periods of time in the area of client care.

An agenda is issued prior to the meeting to present ongoing discussion topics, and staff are encouraged to add new or additional topics to the agenda as they see necessary. Meeting minutes are composed and issued following the meetings.

PIEDMONT GERIATRIC HOSPITAL
RESPONSE TO SNAPSHOT INSPECTION, JULY 14, 2000
OIG REPORT #28-00

Finding 3.1: There is inadequate RN coverage for this facility on weekends, during evening and night shifts as well as weekdays on night shift.

Recommendation: Facility management and Central Office develop a plan to correct this deficiency in RN staffing.

DMHMRSAS Response: Concur. Piedmont will continue its recruitment and Retention efforts of the RN staff. Current efforts include ongoing advertisement, sign-on bonus es, flextime, weekend/shift differentials, paid relocation expenses and continuing education/nursing scholarships. Piedmont will include the nursing staff in the development of a more fully developed Nursing Retention Plan. This plan proposing recommendations will be submitted to the Central Office by September 30, 2000.

6 Month Status Report: 7/1/01
There are three RNs on the evening shift on weekends as well as weekdays. One (1) RN is on the Admission Unit and two (2) supervisors to cover the remaining four shifts. On the night shift on the weekend there is one (1) RN on the Admission unit and one (1), sometimes two (2) supervisors to provide coverage for the other four units. PGH will work with the Director of Human Resources in Central Office to develop a budget plan to hire the additional RNs. To meet the DOJ requirements the facility will need 3 additional RNs with a ratio of 1:19 on the evening, weekend and night shift.

OIG Comment - Interviews indicated that the facility does not have per unit RN coverage consistently during the non- day shifts. There is an RN supervisor available but LPN's attends to unit care. The knowledge base for making on-going assessments and clinical judgments for this vulnerable population often with multiple health-related issues is critical and requires at the least the expertise of a registered nurse. This finding is ACTIVE.

6 Month Status Report: 01/01/02
The facility's current nursing staff has been deployed to cover the evening, night and weekend shift. (Please refer to the July 1, 2001 response) The Nursing Director continually works with the existing Nursing staff in balancing the coverage and retaining the present nurses and making the best combination of unit/shift assignments possible to maintain coverage. The facility will continue to deploy Nursing staff in an attempt to provide adequate unit coverage across shifts. And the facility will continue to downsize to meet DOJ staffing coverage.

OIG Comment- Interviews with administrative staff indicated that the facility continues to function without an RN available on each unit on each shift. Efforts have been made by the facility to secure additional funding to hire the complement of nurses necessary to meet this

requirement. This is a critical concern in addressing the medical needs of this complicated population. This finding is ACTIVE.

6 Month Status Report: 07/01/02
The Nursing Director continues to work with the existing Nursing staff in balancing the coverage and retaining the present nurses and making the best combination of unit/shift assignments possible to maintain coverage. The facility will continue to deploy Nursing staff in an attempt to provide adequate unit coverage across shifts. Also, Piedmont has continued to schedule a RN on each of the five units for the evening shift when RNs are available. At this time, PGH maintains a minimum of two RNs on the night shift in the hospital. PGH will continue efforts to enhance RN staffing on the night shift. It is hoped that the market adjustment plan for primary nurses being implemented will enhance recruitment and help with retention of nurses.

PIEDMONT GERIATRIC HOSPITAL
SNAPSHOT INSPECTION
MARCH 25, 2002
OIG REPORT # 58-02

Finding 1.1: Overall the facility was clean and well maintained but institutional in appearance.

Recommendation: Continue to provide a well-maintained environment while exploring new ways to adapt the facility for this population. Observe safety precautions with the proper disposal of gloves.

DMHMRSAS Response: The Department appreciates the OIG compliment and recognition of the facility staffs' efforts. To further enhance the environment, PGH has received the first report from its interior design engineer. When the interior design report and plan is finalized (June 2002), PGH staff will use that information to develop a long-range plan for improvements to the internal environment of the entire facility.

Safety precautions for the proper disposal of latex gloves were reviewed in the PGH staff Annual In-Service for Infection Control that took place in April 2002; and this issue will be addressed annually in the future.

6 Month Status Report: 07/01/02
During FY 2002-03, when funds are available, Piedmont will use the interior design plan when any work is done for environmental improvements. Proper disposal of latex gloves is reviewed in annual inservice training sessions.

Finding 2.1: Staffing patterns were minimally adequate.

Recommendation: Enhance staffing ratios so that there is more access to RN staff per patient.

DMHMRSAS Response: While PGH current staffing meets safety standards, the Department recognizes the need to have a full complement of nursing staff. In an effort to fill all nursing positions, PGH has maintained continuous recruitment for RNs and LPNs and continues to ensure that nurses now on-staff are deployed to best meet the needs of the patient population. To facilitate access to RNs on-duty, radio communication is maintained with all patient care units. Piedmont continues to experience a relatively low staff turnover rate compared to the national average of health care facilities and other DMH facilities.

6 Month Status Report: 07/01/02
PGH continues to use continuous recruitment for RNs and LPNs and ensures that nurses now on-staff are deployed to best meet the needs of the patient population. On 5/31/02 an Open House for RNs and LPNs was held. From this effort, two RNs are applying for vacant positions. One of three LPNs assisted by PGH to attend RN School, has completed school, passed State Boards and will fill one of the vacant RN positions. The two others accepted employment elsewhere. Piedmont has developed a market adjustment plan in salaries of the RNCA (primary nurse) in an effort to retain present staff. To facilitate access to RNs on-duty, radio communication is maintained with all patient care units.

Finding 2.2: Nursing coverage during the evening and night shifts does not provide for 1 RN per unit.

Recommendation: Continue to pursue the hiring of these positions for the well being of these often medically complicated and fragile patients.

DMHMRSAS Response: [Also refer to Response to Finding 2.1] PGH has continued to schedule a RN on each of the five units for the evening shift. At this time, PGH maintains a minimum of two RNs on the night shift in the hospital. PGH will continue efforts to enhance RN staffing on the night shift.

6 Month Status Report: 07/01/02
PGH has continued to schedule a RN on each of the five units for the evening shift, Monday through Friday to facilitate program implementation. At this time, PGH maintains a minimum of two RNs on the night shift in the hospital. There are one classified and 2 hourly RN vacancies on the night shift. PGH will continue efforts to enhance RN staffing on the night shift. It is hoped that the market adjustment plan being implemented will enhance recruitment and help with retention of nurses.

Finding 3.2: Linkages between active treatment, barriers to discharge and the treatment planning process was evident in records reviewed.

Recommendation: Consider the active sharing of this process with other facilities serving segments of the geriatric population.

DMHMRSAS Response: The Department appreciates your recognition of staff efforts regarding discharge preparation. A new format for the Facility Directors meeting is being developed which, in the future, will enhance the sharing of exemplary practices between facilities. PGH is willing to share this information with other geriatric treatment units.

6 Month Status Report: 07/01/02
PGH will share efforts regarding active treatment, barriers to discharge and the treatment planning process with other geriatric treatment units as the opportunity arises at future Facility Director's meetings. .

SOUTHSIDE VIRGINIA TRAINING CENTER
RESPONSE TO INSPECTOR GENERAL REPORT- PRIMARY INSPECTION
DECEMBER 9 & 15, 1999; JANUARY 4 & 5, 2000; APRIL 3, 2000
OIG REPORT # 18-00

Finding 2.1: The facility has established procedures for the use of locked time-out and the use of restraints. This does include the use of "training restraints" or program restraints.

Recommendation: The appropriate use of "program restraints" will need to be considered in the reworking of the Human Rights regulations.

DMHMRSAS Response: Concur. SVTC tracks every type of physical and mechanical restraint it uses and has systems in place to prevent abusive practices. These systems include the Behavior Management Committee as well as the local Human Rights Committee to monitor programs to ensure that least restrictive options are utilized. SVTC does not use seclusion, and less than 1% of restraint use is classified as behavioral emergencies. The majority of restraints used at SVTC are for the purpose of deterring self-injurious behaviors. These restraints are typically mittens, which do not restrict movement, and are of short duration (1-5 minutes).

The Human Rights Regulations do not address the specific use of "program restraints" as these regulations are intended for broad-based use by state-funded facilities and private providers. However, specific guidelines regarding MR Training Centers' restrictive procedures, such as programmatic use of mechanical or physical restraint and time-out (not locked), are addressed in the Draft Departmental Instruction- *Behavioral Treatment Procedures,* when the restraint or time-out is part of a behavior management plan.

6 Month Status Report: 7/1/01
Currently the new Human Rights Regulations and Departmental Instructions are under administrative review.

OIG Comment - *The facility is awaiting the approved version of the DMHMRSAS directive, currently under review, in order to draft appropriate policies and procedures. This finding is ACTIVE.*

6 Month Status Report: 01/01/02
The DMHMRSAS has refined medical, emergency and programmatic restraint definitions and the facility has adjusted their policies to the new definitions. Also, they will revise existing policies to be in compliance with the newly released Human Rights regulations that were recently passed. This will be completed early in 2002.

OIG Comment – Interviews with administrative staff and review of documents indicated that the facility has adjusted its policies and procedures to address the new human rights regulations. Thirty standard operating procedures were submitted to the Central Office and local human rights committee for review on 2/28/02. All but four of those submitted have been approved at the time of this April follow-up visit. The training of staff is expected to be completed by July 1, 2002. Administrative staff indicated that it will be difficult for the facility to complete the training as required for the 1400 employees of the Center as the training tapes have not been forwarded by the Central Office. Administrative staff, department heads and other management staff have been trained. The facility plans on developing its own training materials if the tapes from CO are not forwarded in the very near future. Because facility staff have not completed training on the new Human Rights regulations, which includes the use of seclusion and restraint, this finding remains ACTIVE.

6 Month Status Report: 07/01/02
SVTC will continue to ensure that staff are knowledgable about and comply with the new Human Rights Rules and Regulations as well as Departmental guidelines regarding these new rules and the Departmental Instruction on restraint use. SVTC reports that use of emergency restraints remain at near zero levels. Instances of emergency restraints at SVTC have numbered between 0-2 monthly since November 2001. SVTC has reviewed the new Human Rights Regulations for implementation. Based on that review, SVTC is revising applicable facility policies and procedures; and additionally, initiated supplemental staff training, which is scheduled for completion by 9/1/02.

Finding 3.1: Several disciplines at SVTC do not meet the staff-to-patient ratios established for Northern Virginia Training Center by agreement between the Commonwealth of Virginia and the Department of Justice.

Recommendation 3.1: Central Office DMHMRSAS staff should work closely with SVTC leadership to develop a clear plan for the current inadequate ratio of professional staff to residents at this facility.

DMHMRSAS Response: It is the general goal of the Department to implement a targeted approach to quality improvement to achieve professionally recognized clinical best practices in state facilities. The objective is to bring all state mental health and mental retardation facilities up

to the active treatment and staffing levels provided in the Department of Mental Health, Mental Retardation and Substance Abuse Services' settlement agreements with the U.S. Department of Justice, under the Civil Rights for Institutionalized Persons Act. We will continue to work toward achieving this objective through the appropriate realignment of internal management practices, and resource allocation initiatives that are based on consumer and/or family choice.

In regard to SVTC, although the prior request for funding of DOJ-level staffing made by DMHMRSAS did not result in an increase to the FY 2001 SVTC budget, there has been some accumulation of funds in the first quarter. The accumulation of funds has been caused due to turnover and vacancies in SVTC 's Human Service Care Worker positions and others, including OT and Speech Pathology staff. There have been unexpected demands competing for these savings in addition to increased personnel costs associated with the re-organization of residential units and overall strengthening of management oversight. Several examples of current demands include:

- $450,000 in costs for emergency repairs to boilers providing heat and hot water to SVTC, CSH and HDMC funds
- $150,000 set aside pending a problem analysis being conducted with Verizon re: issues with the campus phone system

Given requirements such as these, SVTC continues to take an incremental approach to establishing professional positions. Each decision to establish a professional position must be weighed against competing priorities within SVTC and support for the Petersburg Complex. Therefore, DMHMRSAS continues to believe the prudent approach to addressing the large-scale need represented by DOJ-level staffing is the legislative/addendum process which supports our staffing needs as originally pursued.

SVTC must operate within the parameters of its budget allocation, as do all other facilities. It is projected there will be no administrative savings to move into direct care positions at this time. However, they do routinely review budget expenditures for purposes of determining opportunities for increasing direct care ratios within appropriations.

Physical Therapy Staff

It is important to note that four (4) physical therapists and four (4) licensed physical therapy assistants are on board. These eight (8) positions have remained filled. SVTC has sought a contract physical therapist since April 2000 to dedicate to triennial evaluations of individuals not receiving PT services. Current discussions with a contract agency are showing some promise.

SVTC's Physical Therapy Department as a whole has experienced some change in staff that has had a supportive effect on therapists. After almost two years of recruitment efforts, a full time rehabilitation engineer was hired in April 2000 and remains on board. This position focuses on making wheelchair adaptations and is assisted by lab mechanics. An additional lab mechanic position was recently established to make a total of three (3) positions. Recruitment efforts for a part-time lab mechanic initiated in July 2000 continue as well. The PT Director is retiring in December; however, recruitment efforts are underway, and there are several candidates for the position.

Nutritional Management Staff (OT, Speech/Language)

As difficult as it is to recruit for occupational therapists and speech/language therapist positions, it is even more difficult finding candidates with nutritional management expertise. Such "swallowing specialists" may be recruited as either an OT or speech/language therapist. Both the Occupational Therapy and Communication Skills (speech/language and audiology) departments are continuously engaged in maintaining or replacing staff for both nutritional management as well as traditional clinical functions.

Over the last few years SVTC has worked hard to maintain at least three swallowing therapists; the staffing pattern has been two speech therapists and one occupational therapist. However, in the April 2000-November 2000 time frame, there has been significant turnover in these positions. The reasons for this turnover are that there is a high demand for these specialized positions in the community, coupled with more competitive salaries. SVTC responses to the turnover situation included:

A speech/swallowing therapist that resigned in April to return to school was contracted with to continue her nutritional management work on weekends. A permanent replacement was hired in June. The weekend contract arrangement continues with the original speech therapist.

Both speech therapist swallowing specialists resigned during August-September 2000; both positions are being recruited for, and several applications have been received. It is estimated that these positions will be filled, given the availability of the applicant, within sixty days.

Two speech assistant positions were established with the hope that one full time equivalent will be devoted to nutritional management support. One position was filled on October 25, 2000 and she will dedicate 50% of her time to Nutritional Management Therapy. The remaining position was re-advertised and several candidates have applied. It is estimated that this position will be filled, given the availability of the applicant, within sixty days.

One OT swallowing specialist was hired May 2000, but resigned August 2000. A full-time OT staff dedicated to nutritional management is resigning effective November 30, 2000. Recruitment for these replacements has already begun.

Recruitment and retention

The normal recruitment of therapist positions is often extended over a 6-week period of time. Media approaches to recruitment have been nationwide through the Internet, professional publications, colleges and universities, and local newspapers. In addition, the facility has offered three educational scholarships over the last two years for OT and PT positions. An OT scholarship graduate will begin employment with SVTC in January 2001 in a newly-established OT position.

Retention of these valuable, but scarce professionals, is an ongoing concern particularly for swallowing therapists as noted above. SVTC has included an in-line adjustment for PT, OT and speech therapist positions in a recent proposal acting upon compensation reform.

Please rest assured the Department will continue to monitor all state facilities to ensure the continued progress in moving toward our staffing objectives and improving the quality of care to all constituents of the Commonwealth.

6 Month Status Report: 7/1/01
SVTC has continued to seek ways to increase staff in the therapies. Difficult-to-fill positions such as Speech Pathologists have been converted to (more available) Occupational Therapists. Other positions have been converted to Therapy Assistant positions. Since November 2000 SVTC has created a net increase of one Therapist and three Assistant Therapist positions. Several vacancies have been filled, and a part-time contract was established with a veteran PT to conduct triennial evaluations. This incremental approach to strengthening the therapies has been helpful.

OIG Comment - *There has been an ongoing process demonstrated through interviews to enhance professional staff within the facility. Plans are to continue these efforts. It is felt that census reduction will be the key for attaining appropriate staff to resident rations for those positions. This finding is ACTIVE.*

6 Month Status Report: 01/01/02
SVTC has continued to seek ways to increase staff in the therapies areas. Regarding Therapy/Assistance Therapy positions, an additional Licensed Physical Therapist Assistant position was created and filled during the past six months. A part-time Physical Therapist position was discontinued after completion of triennial evaluations on all clients as recommended by the CRIPA consultant. Physical Therapy has gained two positions; and Occupational Therapy has gained four positions.

OIG Comment – Interviews indicated that SVTC has sought to increase professional staff as funding is available. The facility is currently under a hiring freeze but approval has been obtained through the Executive Steering Committee for positions viewed as critical. These hires, even though identified as critical, are still viewed as exceptions. The facility identified that it needs 43 positions in order to meet the same standards established through the settlement agreement between the Department of Justice and Northern Virginia Training Center. Nursing and direct care staff positions have been considered the priorities for replacement when vacancies occur. On the date of the inspection, interviews for the Director of Nursing position were taking place. During the past six months, SVTC added an licensed physical therapy aide position and a part-time physical therapist. The facility lost one occupational therapist and hired four. The facility has also lost one full time speech therapist, which is a difficult position to fill for this facility. SVTC continues to move towards census reduction. Fifteen persons have been placed in the community during the past six months. The facility has established a targeted reduction of between 30 to 35 persons each year until they reach the target census of 200 residents. This finding is ACTIVE.

6 Month Status Report: 07/01/02

SVTC continued to seek staff for the therapies via continuous recruit, although a commitment to hire requires approval by the facility's Executive Steering Committee. Also, the continuous recruit status of therapist position has been re-instated in the state Recruit system.

As of this writing, the SVTC therapies are as follows:

Occupational Therapy:
Therapist positions = 8, of which 7 are filled;
COTA positions = 4, of which 4 are filled;
Physical Therapy:
Therapist positions = 4, of which 3 are filled;
LPTA positions = 5, all of which are filled
Speech Therapy:
Therapist positions = 1.5, of which 1 is filled;
Speech Assistant positions = 3, of which 2 are filled.

Finding 8.1: SVTC does not have a clear vision regarding its evolving role in the treatment of the Mentally Retarded in the Central Virginia area.

Recommendation: A plan should be developed regarding the role and size of SVTC over the next several years.

DMHMRSAS Response: The DMHMRSAS Comprehensive State Plan for 2000-2006 proposes that by the end of 2006 SVTC would consist of 249 beds. The reduction from SVTC's current census of 450 will be accomplished by the placement of clients in appropriate community settings and supported by the choice of the client and their family or guardian. To accomplish this goal, SVTC and the CBSs in its catchment area have begun to work more collaboratively regarding treatment planning and community discharge planning and placements. The vision for SVTC can be described as a regional Residential Facility serving clients with severe/profound mental retardation who require extensive supports for behavior and/or physical needs.

6 Month Status Report: 7/1/01

Since the initial plan of correction was developed the SVTC census has dropped from 450 to 423. The closing of the last North Campus residential building is in progress. Transitional staffings including CSB staff are held to develop a service plan for the community placement. SVTC conducts transitional visits of clients to community settings prior to discharge and follow-up visits after discharge. Individuals with physical needs at the skilled level are served in collaboration with Hiram W. Davis Medical Center (HWDMC), when necessary. Community individuals that need intensive behavior supports are placed in the intensive behavior unit when necessary and plans for return to community placement developed.

OIG Comment - *The facility has designed a plan to focus on census reduction and currently has an identified 100 residents appropriate for discharge pending the availability of appropriate community placement. This finding is ACTIVE.*

6 Month Status Report: 01/01/02
Building #3 & 4 have been closed, all clients now reside on the south campus. The goal is to reduce the census in cottages to 16; currently 10 of 13 duplexes have a census of 16 or under. Community placement has slowed based on availability of community resources. SVTC has placed 11 customers since July '01 in the community. DMHMRSAS has approved Medicaid waiver money for 39 consumers statewide based on a first come, first serve basis. SVTC has 53 clients recommended for placement who have active CSB participation; CSB is the responsible entity to request the Medicaid Waiver dollars. SVTC is in contact with CSBs regarding placements with two clients projected for placement in February.

OIG Comment - Interviews revealed that 15 persons have been placed in the community since October of last year. SVTC has a target of placing between 30-35 persons a year. The targeted census reduction is for the facility to have an operating capacity of 200 beds. Placement has become more difficult as those targeted for discharge are more medically fragile than those previously successfully placed. This area of the Commonwealth would benefit from the development of a Center of Excellence, which serves community residents and is modeled after the Northern Virginia Training Center program. This finding is ACTIVE.

6 Month Status Report: 07/01/02
SVTC has made progress in reducing the census of client living areas. Since the last report, SVTC has had five discharges. At this time, 12 out of the 14 facility duplexes have a census of 16 or less, leaving only two duplexes with a census of 16 or more: C-18/19, 17 clients; and C-28/29, 18 clients. In addition, SVTC will continue to address census reduction in those two duplexes, as well as all other living areas across the campus, by monitoring vacancies and by making client movements if placement is deemed appropriate for the client.

SOUTHSIDE VIRGINIA TRAINING CENTER
SNAPSHOT INSPECTION
JUNE 12, 2002
OIG REPORT #62-02

A Snapshot Inspection was conducted at Southside Virginia Training Center on June 11-12, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and active treatment.

A tour of eleven duplex cottages on the facility's campus revealed that overall, the units were clean, comfortable and well maintained. Staff efforts to make the environment homelike were evident throughout the tour.

Given the complexity of the residents served within this facility, the number of staff present was minimal. Staffing patterns did exceed the minimum numbers as established by SVTC. The inspection team was informed that the numbers of staff present the night of the inspection was not representative of the recent past. Recent staff shortages have resulted in low staff to patient ratios over the last several weeks.

Evening activities were evident. Active treatment programs were reviewed in the areas of prevocational, pre-community living and community living training.

The facility has been working on establishing a cooperative relationship with the local community college to provide enhanced career opportunities for the staff through grant application for federal funds to provide on-site classroom training opportunities, a child development center and after school program.

Finding 2.1: Staffing patterns were consistent with the prescribed facility standards.

Background: Interviews and observations demonstrated that the expected number of staff were available. All units visited had a staffing ratio of 2:8, except for Unit 30 in which one staff member was off the unit on break; Unit 31 had a 3:8 ratio; Unit 19 had a 1:8 ratio due to the second staff member being off campus for personal reasons; and Unit 28 had a ration of 3:10.

During interviews staff indicated that this was a full compliment of coverage, which was unusual due to recent staff shortages. One staff member indicated that there had been 11 separations from service on the evening shift in the past few months and nine on the night shift. During this inspection only one person reported working overtime during the shift.

Recommendation: Maintain current efforts to sustain facility staffing expectations.

Finding 2.2: There was significant variability among staff in ability to define examples of abuse and neglect.

Background: Out of ten staff interviewed five could not articulate working definitions of abuse and neglect. This represents a significant number of persons who would have difficulty maintaining the "watchful eye" necessary to actively prevent abuse and neglect from occurring. Without having a clear professional definition of abuse and neglect, staff may call upon their own personal ideas and experiences regarding discipline or behavior modification. Four out of the five staff that had difficulty relaying examples had less than five years of experience, one out of the five had almost thirty years but did not believe that abuse could occur to wheelchair bound residents, only incidents of neglect. Each staff relayed that they had received or would receive abuse and neglect training on an annual basis.

Recommendation: Consider conducting a competency evaluation of staff knowledge regarding abuse and neglect and conduct retraining as necessary.

Finding 2.3: SVTC is developing a plan for becoming a workforce development pilot project site.

Background: The facility has been working on establishing a cooperative relationship with the local community college to provide enhanced career opportunities for the staff through a grant application for federal funds to provide on-site classroom training opportunities, a child development center and after school program. A survey of need was conducted with staff The survey noted that 30 individuals expressed an interest in pursuing nursing classes, 90 for classes in information technology, and 31 in allied health care professions such as physical therapy. Supportive service needs such a child or elder care needs were explored and addressed as ways of addressing potential barriers to staff members being able to successfully attend classes.

Recommendation: Maintain this commitment to provide career advancement training and professional development to all staff.

Finding 3.1: SVTC provides a variety of active treatment for residents.

Background: The inspection team toured and observed active treatment that served 250 residents of the 405 total facility population. The facility begins to transport residents to their designated active treatment program at 8:15am; this is completed by 9:45am. Active treatment is offered in varying segments from 9:00am -2:30pm. The inspection team observed active treatment that included, pre-vocational training; pre-community living training; and community living training. Each segment of active treatment was developed specifically to the individual needs of each resident. For example, two classes were comprised of visually impaired residents and the active treatment focused on environmental manipulation and included visual stimulation room. The inspection staff observed that the staffing patterns were consistent with facility expectations and because most residents remain within the educational building, the staffing included a nurse, Physical, Occupational and Speech therapy and nutritional management services located on site.

Recommendation: Continue to offer active treatment that has been developed to match each resident's varying developmental needs.

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
SNAPSHOT INSPECTION
MAY 7, 2002
OIG REPORT #60-02

A Snapshot Inspection was conducted at the Southern Virginia Mental Health Institute in Danville, Virginia during May 6 - 7, 2002. The purpose of a snapshot inspection is to conduct an unannounced review of a facility with a primary focus on three quality of care areas. The areas are as follows: the general conditions of the facility, staffing patterns and concerns and the activity of patients.

Overall, the facility was clean and well maintained. Recent renovations changed the placement of the nurses' station, which has resulted in increased opportunities for interactions between the staff and patients. Patients related feeling both safe and comfortable within the facility.

Staffing patterns were noted to meet the expectations outline by policy and procedures for this facility. Nursing staff were identified by the patients as most the staff members most significant in their recovery process.

The facility provides individualized treatment planning. There was evidence that the patients were provided with multiple opportunities to participate in the development of treatment and discharge planning.

Finding 2.3: SVMHI is reducing funding for staff training for FY 2003.

Background: OIG inspection team interviews with administrative and direct care staff indicated that in FY2002, the facility had committed funding for career advancement and professional training that created an environment of opportunity. All direct care staff commented that they were trained in the facility with a constant offering of inservices that were applicable to the patients they were responsible for treating. In addition they relayed that they knew many or had themselves been able to participate in off campus educational experiences. In the past, the facility had been able to dedicate approximately $13,000 for travel to professional conferences and professional educational stipends. An additional five thousand dollars was used to bring in professional experts.

The facility has reported that for FY 2003, budget reductions will prohibit SVMHI from dedicating any funding for travel and stipend funding. This will not affect the inservices that are provided internally rather it will discontinue funding for professional conferences and professional educational stipends.

Recommendation: Work with the Central Office to formulate availability to continue career advancement education for professional and direct care staff.

Finding 3.3: SVMHI has closed the token store.

Background: Patients interviewed indicated that they were upset when the facility decided to close the token store due to budget reductions. Administrative staff related that the decision was discussed with the patients. The facility will consider reopening the token store if funding becomes available.

Recommendation: None.

SOUTHEASTERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
MAY 29-31, 2001
OIG REPORT # 44-01

Finding 3.3A: The staff at SEVTC maximizes its efforts to provide the residents with active treatment opportunities despite staffing limitations.

Recommendation: 3.3A: Evaluate the need for increased professional staff and/or aides trained in conducting OT and PT activities.

DMHMRSAS Response: This need for increased professional staff and/or aides trained in conducting OT and PT activities has been evaluated and recommendations have been made based on the NVTC Settlement Agreement. Recommendations for increased professional and licensed assistant staffing at SEVTC have been submitted in the Department's budget request.

6 Month Status Report: 01/01/02
The Center has hired an additional ½ time OT. Other staff will be added as funds become available. One additional OT and one additional COTA will be added in the FY 2003 budget.

OIG Comment- Interviews indicated that the facility has established hiring priorities. Direct care workers have been identified as the high priority in hiring as funding becomes available. The facility plans on hiring additional professional staff and has projected hiring of an additional OT and COTA. Clerical staff have been acknowledged to be a valuable additional but the facility will hire priority positions prior to adding to the clerical staff. This finding is ACTIVE.

6 Month Status Report: 07/01/02
SEVTC has had continuous recruit for priority positions - one COTA, one LPTA, one speech pathologist, and one recreation therapist. At this time, the Center has hired one speech pathologist and is still recruiting for the other positions.

Recommendation: 3.3B: Consider hiring a secretarial person to use the skill of professional staff more efficiently.

DMHMRSAS Response: The need for secretarial assistance at SEVTC has also been evaluated and would be beneficial; however, this is of a lower priority as compared to SEVTC's need for direct service staff members, professional staff, and qualified therapy assistance (COTAs, LPTAs, psychology assistants.). As these positions are filled, secretarial assistance will be reconsidered.

6 Month Status Report: 01/01/02
The facility continues to look to fill priority positions. SEVTC will also explore the possibility of obtaining clerical interns from surrounding schools and colleges.

OIG Comment- Interviews indicated that the facility has established hiring priorities. Direct care workers have been identified as the high priority in hiring as funding becomes available. The facility plans on hiring additional professional staff and has projected hiring of an additional OT and COTA. Clerical staff have been acknowledged to be a valuable additional but the facility will hire priority positions prior to adding to the clerical staff. This finding is ACTIVE.

6 Month Status Report: 07/01/02

Direct care staffing continues to be a major priority at SEVTC. In addition to the recruiting for professional staff reported in January, the Center continues to recruit and hire direct service personnel for the cottages and for ancillary programs. The Center is also recruiting to fill two new evening shift supervisor positions.

Finding 4.3: All the space does not seem to be used in an optimal manner.

Recommendation: Consider the re-allocation of space and equipment and/or residents so that residents in wheelchairs are in a larger, more usable space. If this is not possible, consider renovations of the cottages where residents in wheelchairs reside.

DMHMRSAS Response: The allocation of space at this facility has been considered a number of times. The Department has developed plans for renovation of the cottages at SEVTC and these plans are represented in current capital improvement projects. Many of the residents require special wheelchairs and medical apparatus to maintain their daily lives and lots of space is required for freedom of movement. The Department has proposed to construct three new structures, constructed in three phases. These new buildings would be designed to provide for the room needed to work with persons with requiring wheelchairs a daily basis. As funding becomes available for capital improvement projects, construction of the new buildings at SEVTC will begin.

6 Month Status Report: 01/01/02
The Department waits for the Capital Bond Bill approval which will allow for the facility to begin the planning and design phase of the building improvement in FY 2003.

OIG Comment- Interviews revealed that the facility has conducted several reviews regarding the use of space and has made a request for extensive renovations to the cottages as well as new construction as funding becomes available. The team was informed that these plans have been outlined in the capital improvements plan. This finding is ACTIVE.

6 Month Status Report: 07/01/02
The Department's Central Office will once again put forth a capital improvement budget request to the state Department of Planning and Budget.

Finding 4.4: Storage space is needed for unused equipment and excess supplies.

Recommendation: Review the current practice for storing unused equipment and excess supplies and develop alternative storage areas.

DMHMRSAS Response: Storage space has been reviewed, particularly in relation to item 3.2 and recommendations that the Center hire at least one rehabilitation engineer. The capital improvement project includes storage space for the cottage equipment.

6 Month Status Report: 01/01/02

See response to Finding 4.3 regarding potential for space improvement within this Facility.

OIG Comment- Interviews revealed that the facility has conducted several reviews regarding the use of space and has made a request for extensive renovations to the cottages as well as new construction as funding becomes available. The team was informed that these plans have been outlined in the capital improvements plan. This finding is ACTIVE.

6 Month Status Report: 07/01/02
(Please refer to our Update for Finding 4.3) Some improvements in storage are anticipated with the employment of a rehabilitation technician, who will advise SVTC on proper utilization of, and any needed re-design of, existing equipment. Storage improvements are anticipated from enhanced preventive maintenance, rapid processing of older wheelchairs and equipment, and greater efficiency in parts storage.

Finding 8.1 The majority of staff interviewed indicated that shortages in direct care staff poses the greatest challenge for providing quality care to residents of the facility.

Recommendation: Continue to explore options for recruiting and retaining staff in these key positions.

DMHMRSAS Response: Concur. SEVTC will continue its recruitment and retention efforts for direct service staff members, professional staff, and qualified therapy assistance (COTAs, LPTAs, psychology assistants.). Current staff efforts include ongoing advertisement, flextime, shift differentials, and continuing education scholarships.

6 Month Status Report: 01/01/02
Since the last report, the Center has run a more extensive advertisement campaign which has produced more applications for positions. The advertising budget has increased by 50% and advertisements appear in newspapers weekly in larger block form. A link has been for job searchers on the SEVTC website regarding current position openings. Relationships have been established with the local Navy bases regarding SEVTC openings and job posting are given to persons exiting military though TAP classes. VEC and community college posting continue.

OIG Comment – Interviews with supervisory staff indicated that the facility has made a concerted effort at securing more direct care staff. As noted in the progress report, advertising has been expanded and a greater applicant pool noted as a result. The facility has not completed the hiring of these positions and it is for this reason this finding remains ACTIVE.

6 Month Status Report: 07/01/02
SEVTC remains committed to maintaining intensive recruitment efforts for all priority positions. The recruitment of direct service personnel remains a top priority effort for the Center.

SOUTHEASTERN VIRGINIA TRAINING CENTER
RESPONSE TO PRIMARY INSPECTION REPORT
FEBRUARY 17-18, 2002
OIG REPORT # 54-02

Finding 1.1: The living environment in Building 29 was unsanitary and presented hazardous situations for residents.

Recommendation: Insufficient numbers of staff can not safely manage resident needs and maintain a safe environment. SEVTC needs to review practices for building maintenance to assure that cleanliness and safety standards are maximized within existing resources. This is not likely to be able to be permanently resolved without additional resources.

DMHMRSAS Response: The Center agrees that a safe and sanitary environment is fundamental. SEVTC maintains a lower staff: client ratio in this large cottage due to residents being higher functioning and in order to more richly staff cottages where clients have greater needs for individual care and supervision. While the relatively greater independence of this group of twenty clients makes a lower staffing ratio possible, it also creates special challenges for bathroom maintenance. The following steps have been taken in an effort to address the recommendation:

1. Staffing in this cottage will be increased using new funds;
2. Two new evening shift supervisor positions are being created for campus oversight with recently added funds on observation instrument will be put into place to assist in oversight activities;
3. Bathroom maintenance checks will be restored to an existing 30-minute day and evening resident check schedule. Similar bathroom checks will be scheduled hourly during the night;
4. Housekeeping will revisit cottages in the late afternoon to ensure that trash and significant problems are resolved before leaving campus;
5. Several clients who have previously mastered toileting programs, including flushing, will be re-evaluated and appropriate training re-instituted as necessary;
6. The team leader will conduct in-service training periodically regarding the above procedures; and
7. The team leader will follow-up to ensure that these procedures are being followed.

At this time, basic cottage sanitary maintenance at certain times of the day will remain a cottage staff function.

6 Month Status Report: 07/01/02
<u>SEVTC continues to maintain a safe, sanitary living environment for its clients.</u> Revised maintenance checks of all bathrooms continue. Progress with the plan outlined previously continues. New cottage positions and the evening supervisor positions have been established. Recruiting efforts for those positions continue. Bathroom checks are conducted by cottage staff members on a 30 minute schedule; and housekeepers continue late afternoon monitoring in the cottage. Re-evaluation of residents' toileting skills has

been completed and programs were reinstated when needed. Supervisors have reviewed the overall plan with staff members several times and continue to monitor. Due to staff efforts, several clients with a history of poor toileting skills currently can self-initiate and complete toileting tasks independently—though not always as neatly as might be desired.

Finding 1.2: Improper disposal of a razor blade by a staff member was observed.

Recommendation: Assess the need to re-train staff on the proper disposal of sharps and hazardous waste.

DMHMRSAS Response: With one exception, all clients in this cottage shave with (or are shaved with) electric razors. The exception is occasional use of a disposable razor to shave the head of man who prefers this style. Safety razors and single- or double-edged blades would be very dangerous, but these razors and blades are not used in any Center cottage. Disposable razors are used with some residents in other campus cottages. Cottage staff have been reminded and have reviewed disposal of used disposable razors to ensure that this is done safely. A sharps box is maintained in every cottage.

6 Month Status Report: 07/01/02

New sharps containers were purchased and installed for each cottage and for the infirmary at SEVTC. Through special training sessions, cottage staff have been instructed in proper sharps disposal. SEVTC is monitoring staff compliance with proper sharps disposal; and, when indicated, will address instances of non-compliance through the supervisory process.

Finding 2.1: Staffing numbers were at the minimum required level.

Recommendation: Review staffing deployment to assure that patterns meet the level of supervision necessary to safely manage basic body functions as well as provide for active treatment needs of the residents.

DMHMRSAS Response: Deployment will be reviewed as new positions are added utilizing new funds. Recruitment for cottage staff positions has commenced. The facility will assure that staff are deployed to meet Medicaid minimums and to address activity in the various cottages.

6 Month Status Report: 07/01/02

SEVTC has been engaged in continuous recruitment of cottage staff and priority positions . Since January 2002, approximately 35 cottage staff have been hired. Cottage staff turnover continues to be a challenge for the facility.

Finding 3.1: Residents were observed to be engaged in a variety of leisure activities for a limited amount of time.

Recommendation 3.1: Continue to provide a variety of activities to address both the leisure and active treatment needs of the residents. Review staffing patterns to assure that the treatment needs of the residents are adequately addressed.

DMHMRSAS Response: Recreation staff have adjusted their schedules to concentrate more of their time on providing activities in the early evening hours and during weekend hours.

6 Month Status Report: 07/01/02
To assure that client treatment needs are adequately addressed, SEVTC has supplemented recreation staffing and has revised staff schedules to increase evening activities, such as skill-improvement and recreation.

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
MARCH 19-20, 2001
OIG REPORT # 40-01

Finding 1.2: Pony walls in the C Building are potentially dangerous and increase this unit's ward like appearance.

Recommendation: Proceed with the planned renovation and relocation of the adolescent services unit into the main Bagley Building.

DMHMRSAS Response: As is noted in the report the planning for the renovation of space in the Bagley Building has been underway for some time. An identified problem with the plumbing system will further delay the actual move of the adolescent patients into the Bagley Building. However, funds have been identified to accomplish the renovation and the plumbing repairs. It is expected that the renovation and completion of the plumbing repairs will be accomplished by February 2002. After completion of these projects, a date to remove the Adolescent Unit will be selected that will ensure a smooth transition into the Bagley Building.

6 Month Status Report: 01/01/02
The plumbing repairs proceeded ahead of schedule and were completed in November, 2001. A contractor has been selected to complete final renovations in preparation of the Adolescent Unit relocation. SWVMHI now expects this relocation to be placed in mid to late January 2002 barring any unforeseen circumstances or delays.

OIG Comment – Interviews and observations demonstrated that efforts to relocate the adolescent unit continue. At the time of the follow-up visit, the completion of the transfer was slated for before the end of March. Because the renovation has not been completed, this finding is ACTIVE.

6 Month Status Report: 07/01/02

Planned renovation and relocation of the Adolescent Services Unit into the main Bagley Building was completed on January 21, 2002. The B Building (former Adolescent Unit) is now closed to SWVMHI patient occupancy.

SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
DECEMBER 4-5, 2001
OIG REPORT #51-01

Finding 3.2: There is inadequate space for effective programming.

Recommendation: SWVMHI working closely with the Central Office in exploring options for expanding programming space.

DMHMRSAS Response: SWVMHI provides off unit programming in the Blalock and Auditorium Buildings, which have space limitations due to the location of staff offices in these areas. Renovation of the Harmon building will provide for additional Central Program space by allowing staff to relocate to this area. SWVMHI and the Central Office Architectural and Engineering Office have worked together on plans to renovate the Harmon Building for several years. The Institute has designated a portion of their FY 02 operational funds to begin this renovation and Central Office has set aside Asbestos Abatement monies to repair floors and walls subsequent to the removal of asbestos. Plans are underway to contract for these initial repairs, which will allow for some limited relocation of offices. As additional funds are identified, the renovation will be expanded in order to ultimately establish sufficient program space in the Blalock and Auditorium Buildings.

6 Month Status Report: 07/01/02

The Bagley, Blalock and Auditorium Buildings comprise the Patient Care area at SWVMHI. In order to expand program space, SWVMHI is renovating the first floor of Harmon Building so that staff offices can be moved out of the Blalock and Auditorium Buildings, thereby creating additional options for program space in the Patient Care area. The facility contracted with the Department of Corrections (DOC) Construction Unit for repair/painting of walls and the installation of floor covering on the first floor of the Harmon Building. Renovation began in late July, and completion of this phase is anticipated at the end of October 2002. As additional facility funds are available, window air conditioners, computer/telephone service and Life/Safety improvements will be accomplished to facilitate relocation of staff offices to the Harmon Building.

Finding 3.3: Both staff and patients expressed concerns regarding security on the acute units.

Recommendation: Continue to explore methods for enhancing security of both patients and staff.
DMHMRSAS Response:

1. The Director of Security has met with the Hospital Director and Unit Leadership to develop contingencies for increased patient acuity. These plans include having security staff present on the ward when assistance is needed with individuals who have the potential to harm others. If necessary, the Institute will hire and train additional security officers to provide for this ward presence.

2. The Nursing Department has also established a "Float Pool" that Nursing Leadership can deploy to increase staffing on particular units with high acuity. Institute Leadership monitors staff injuries in several committees. (Accident Review, Safety, Nurse Staffing and Risk Management)

3. The Institute Director is also working with a statewide Behavior Management Committee, which is addressing the weaknesses of the current Mandt System, and exploring alternative strategies. (See DMHMRSAS response to Finding 2.1)

4. The Treatment Teams are screening all patients and developing Contingency Plans to deal with those who present a risk for violence. These plans are communicated with all three shifts. When necessary, patients who are identified as having potential for violence are being presented to Clinical Leadership for additional consultation.

5. SWVMHI has been trending self- injurious and violent behavior events on a monthly and quarterly basis. Data indicate that incidents of both behaviors have decreased when compared to the numbers of incidents in previous years. The above measures should help to keep this trend moving in a positive direction.

6 Month Status Report: 07/01/02
1. To further ensure and enhance the security of all personnel at SWVMHI, the following actions have been implemented: • In response to the high acuity trend identified during second shift, additional P-14 Security Officers have been hired/trained to conduct routine patrols of the patient care complex during the time frame. These patrols are in addition to the routine patrol made by Security Officers, Senior. • Security personnel confer with Nursing, Clinical and Medical Staff to identify areas of highest acuity each day to ensure appropriate presence of Security in areas identified. • Security personnel respond to all "Code Alert" announcements to augment Nursing staff and to ensure safety and security of all personnel. 2. The Nursing Department has revised staffing plans for each unit, which address active treatment, acuity, and safety concerns. In addition the wage employee (P-14) pool is being expanded and per diem positions are being added. These strategies, along with the established Float pool, will assist the Nursing Department in having sufficient staffing during high acuity periods. 3. The Institute Director at the time of inspection has moved to the DMHMRSAS Central Office due to promotion to the position of Assistant Commissioner for

Facility Operations. SWVMHI continues to participate in the statewide Behavior Management Committee to develop alternative interventions to MANDT to improve safety and effectiveness in managing aggressive patient behaviors. The Institute has three permanent members on this committee (specifically, a Nurse Coordinator and two training staff).

4. The SWVMHI treatment teams continue to screen all patients and to develop Contingency Plans to deal with those who present a risk for violence. These plans are communicated with all three nursing shifts. When necessary, patients who are identified as having potential for violence are being presented to Clinical Leadership for additional consultation.

5. SWVMHI continues to monitor and trend self-injurious behavior and violent (Aggressive Acts) events on a monthly basis. Data from January 2001 through May 2001 shows that there were 416 of these type events reported, while data from January 2002 through May 2002 show that there were 356 of these type of events reported. This represents a decrease year-to-date in 2002 of 14.4% as compared to the same time period last year. During the same time period SWVMHI experienced a decrease of 33.3% in the number of staff injuries due to aggressive acts. While it is virtually impossible to identify any specific action by SWVMHI as being directly accountable for this progress, it is noteworthy that changes occurred simultaneously with the reductions in the use of Restraint/Seclusion and with an increase in off-ward patient activity. It is far more probable that the decline in these type events at SWVMHI is the result of the Security Enhancement Program, increased staff awareness, increased staffing levels during high acuity periods, and increased staff training. The monitoring of self-injurious behaviors and patient aggression will continue at SWVMHI a part of the facility's effort to reduce risk of injury to staff and patients.

Finding 4.1: The facility has been working towards a fully integrated psychosocial rehabilitation program.

Recommendation: Continue to enhance this program while focusing on renovations that would allow for increased programming space.

DMHMRSAS Response: (See Response to 3.2 above regarding efforts to increase space.) SWVMHI will continue to improve assessment, treatment planning and therapeutic programming using psychiatric rehabilitation technology of which a key component is involving patients in making choices that impact their future. SWVMHI will continue to expand the psychiatric rehabilitation/therapeutic services offered based on patient's needs and preferences. Patients will be surveyed periodically regarding their opinions of the programming offered and whether they meet their needs. Central Rehabilitation Service/OT/RT and other staff will continue to be supervised on the specific competencies needed to ensure provision of psychiatric rehabilitation services. In addition, SWVMHI will explore the expansion of psychiatric rehabilitation curriculum to include vocational, educational and social offerings in order to provide for variety and enhanced services. These curriculum offerings are particularly appropriate when patients do not have control over future living choices.

6 Month Status Report: 07/01/02
SWVMHI will continue to improve assessment, treatment planning, and therapeutic programming using psychiatric rehabilitation technology of which a key component is involving patients in making choices that impact their future. SWVMHI will continue to expand the psychiatric rehabilitation/therapeutic services offered based on patients' needs and preferences. Patients are surveyed quarterly regarding their opinions of the programming offered and whether they meet their needs. SWVMHI resources are being directed to the assessed needs of the patient population, which has resulted in the current focus on engagement and readiness development (which are two of the phases of psychiatric rehabilitation conceptualized by the Boston Center for Psychiatric Rehabilitation). In addition, SWVMHI will explore the modification and expansion of psychiatric rehabilitation curriculum to include vocational, educational, and social offerings in order to better meet patient needs based upon assessment and patient preferences. These curriculum offerings are particularly appropriate when patients do not have control over future living choices. Central Rehabilitation Services/OT/RT and other staff at SWVMHI will continue to be supervised on the specific competencies needed to ensure provision of psychiatric rehabilitation services. Quarterly reviews of staff competencies, skills, and practices are completed and the results included in the quarterly Quality Management reports to the facility Quality Management Committee.

Finding 7.1: The facility is in process of moving the adolescent unit to the Bagley Building.

Recommendation: Complete the move of this unit to the Bagley Building as planned.

DMHMRSAS Response: The Adolescent Unit was successfully relocated to the Bagley Building on January 21st, 2002. Feedback from patients and staff regarding the new environment has been positive thus far. The patients have been pleased to be in the modern building and in the semi-private bedrooms. Staff express that the new Unit is more open and brighter which is conducive to care and a positive therapeutic milieu. By relocating the Unit to the Bagley Building the Adolescents now have year round indoor recreation and program opportunities; and the new Unit will enable a wider range of activities to be provided. Response time to the Unit is much improved, which increases safety for both staff and patients.

SWVMHI will continue to explore reducing its bed capacity to improve staff-to-patient ratio and the quality of patient care. In addition, efforts will continue to ensure provision of therapeutic activities including evenings and weekends. Services will continue to be assessed to ensure that they best meet patient needs and preferences.

6 Month Status Report: 07/01/02
The SWVMHI Adolescent Unit was successfully relocated to the Bagley Building on

January 21, 2002. To date, feedback from patients and staff regarding the new environment continues to be positive. Patients report particular satisfaction with the modern building and the semi-private bedrooms. Staff express that the new Unit is more open and brighter, which is more conducive to care and to a positive therapeutic milieu. The unit relocation to the Bagley Building now provides the adolescents with year-round indoor recreation and program opportunities. Response time to the Unit is much improved, which increases safety for both staff and patients.

SWVMHI continues to regularly review staff-to-patient ratios and the quality of patient care. Efforts continue to be made to ensure that therapeutic activities are provided on evenings and weekends. The auditorium, gym, and ceramic areas have been made available to Adolescent Services for evening and weekend activities/treatment. To better meet the complex clinical needs of this population, a B.S.W. position has been upgraded to (and filled) a M.S.W. Clinical Social Work position. Services will continue to be assessed to ensure that they best meet patient needs and preferences.

Finding 7.2: The facility has instituted a security enhancement project.

Recommendation: Continue to develop this service.

DMHMRSAS Response: Security Staff at SWVMHI have been selected on the basis of their ability to interact comfortably and respectfully with patients and their families. Several of these officers have direct care job experience. The Security Director began his career as a psychiatric aide and is particularly sensitive to the importance of having officers who can interact well with patients and families. Security Staff work closely with Nursing leadership to respond to fluctuating acuity on an hour by hour basis. As a result of the Security Enhancement Plan, patients now have full access to off unit meals and programs regardless of their security needs. Front entrance officers have been trained in customer relations. The Facility leaders consulted with the Office of the Attorney General during the implementation of Front Entrance Security Positions. Consequently the officers have a clear understanding of the boundaries of their authority related to search procedures and contraband control as well as the need to treat visitors with respect and dignity as they perform their duties.

6 Month Status Report: 07/01/02

The SWVMHI Security Enhancement Project has been expanded in recent months with the implementation of the following initiatives.

- Creation of a secure three building patient care complex (Bagley, Blalock and Auditorium) by electronically securing all exterior doors which enable high risk patients to participate in "off ward" activities.
- Development of additional secure exterior courtyards for patient use.
- Minimization of the potential for introduction of contraband into the patient care complex by:
  - Requiring all visitors to enter/exit via main entrance to patient care complex, register visit, receive visitor ID, secure personal items and submit articles/packages for

patient care areas for inspection.

- Pat down search of all new admissions by trained, same gender staff, and inspection of all personal items prior to completing admission process.
- Security, Nursing, Clinical, Medical and SWVMHI Administration are exploring , and implementing as appropriate, methods to streamline the admissions process from the patient's perspective, while maintaining/enhancing a safe and secure environment.

Finding 8.1: Staff identified space and the turnover in direct service assistant positions as the greatest challenges facing the facility.

Recommendation: Continue to address the issue of the staff turnover.

DMHMRSAS Response: Since 1998, SWVMHI has had a standing group (Nurse Staff Committee) which, addresses issues related to staff turnover. They have established Goals for Year 2002 which include the following:

1. Assess salaries and benefits of area healthcare organizations and improve SWVMHI's ability to compete through consideration of increases in shift differentials, weekend staffing plans, self-scheduling enhancements, alternative work shifts, cafeteria benefits, etc.
2. Expand leadership training to include supervisory skills for Nurse Managers.
3. Review implementation of the Head Nurse and Lead Aide positions and make necessary adjustments in what to insure that these recently established career ladder positions are being used as originally intended.
4. Continue monthly monitoring of indicators critical to retention of staff (e.g., number of mandated overtime shifts, staff call-ins, P-14 staff usage, employee injuries, etc.)
5. Enhance recruitment efforts by initiating " Adopt a Student" program that is designed to provide orientation to the facility and to point out the benefits of working at SWVMHI. This program will make positive use of the nursing school affiliations that SWVMHI has with area nursing schools.

SWVMHI's standing committee continues to meet monthly to assess and respond to the recruitment and retention challenges.

6 Month Status Report: 07/01/02

The Nursing Staffing Committee, composed of top nursing and fcaility leadership, continues to meet monthly. This Committee reviews staffing related data such as resignations, terminations, injuries, transfers, and other data that impact adequate staffing: call-ins, mandates, and consults (patient trips outside the facility which require staff to assist with trips). These data are also reported to several other committees (Nurse Managers, Safety, Accident Review, and Risk Management). The goals for 2002 continue to be addressed.

Upon completion of an assessment of area healthcare organizations, a weekend shift

differential and referral bonus have been proposed and placed in the FY 03 budget. Adjustments have been made to make self-scheduling more beneficial to both the employee and SWVMHI; staffing plans for each unit have been revised and approved; alternate work shifts (12 hours – 16 hours) have been seriously proposed with positive responses from some nursing staff. Prospective employees preferring alternate work shifts, cafeteria benefits will be interviewed.

Supervisory training programs have been implemented with Nurse Managers and prospective Nurse Managers attending. In addition, a supervisor training program will be held this year, provided by the Boston Center for Psychiatric Rehabilitation.

As a result of a staff survey regarding nursing unit leadership roles, training programs for both the Head Nurse and Lead Aides will be developed and implemented.

Several nursing recruitment efforts have been implemented, such as "Adopt-a-Student Nurse Program, attending career fairs, visiting schools of nursing (both nurse managers and direct care staff). Nurse Managers are members of the advisory boards of local schools of nursing. An extern program is being explored and most likely will be implemented by Fall 2002. In addition, the Acting Facility Director has been appointed to the Citizen's Advisory Council for the Governer's Center for Economic Recovery that has been established in Smyth County. In this role, emphasis on healthcare careers can continue to be made to county and state leadership.

Finding 8.2: Facility has undergone several environmental changes during the past year.

Recommendation: Continue to complete planned changes in such a manner as to minimize the disruption of services.

DMHMRSAS Response: The Pipe Renovation Project was completed by November of 2001, and all patients were successfully returned to their original units. In preparation for moving the Adolescent Unit into the Bagley Building, Extended Rehabilitation Units were also renovated and relocated. In advance of these planned moves, the SWVMHI Leadership established quality improvement indicators that would allow monitoring of the Extended Rehabilitation Service (ERS) and the adolescent patients' quality of life before, during and after these relocations. These indicators included: Patient Satisfaction, Falls and Accidents, Incidents of Aggression, Seclusion and Restraint, and Level of Active Treatment, among others. Unit leadership monitored these indicators and adjusted as necessary to minimize the impact of these moves on patients. As is indicated above, the Adolescent Unit was successfully relocated on January 21st, 2002. Currently there are no plans for any additional patient re-locations.

6 Month Status Report: 07/01/02

The SWVMHI leadership established quality improvement indicators that would allow monitoring of the Extended Rehabilitation Service (ERS) and the adolescent patients' quality of life before, during, and after these relocations. These indicators included: Patient Satisfaction, Falls and Accidents, Incidents of Aggression, Seclusion and Restraint, and Level of Active Treatment, among others. Unit leadership continues to monitor these

indicators and to make adjustments as necessary to minimize the impact of these moves on patients. Indicator data continue to be reviewed on a monthly basis.

The new Adolescent environment has reduced the potential for adverse events with increased opportunity for patient observation. No adverse or negative effects from the renovation and relocation have been evidenced with either the Adolescent or E.R.S. patient populations. Facility quality improvement data indicated that restraint utilization decreased slightly during the renovation/relocation period. SWVMHI will continue to monitor these indicators. At this time, there are no plans for any additional patient re-locations at SWVMHI.

SOUTHWESTERN VIRGINIA TRAINING CENTER
APRIL 24-26, 2001
OIG REPORT #43-01

Finding 3.5: The facility has conducted several reviews regarding the use of overtime.

Recommendation: The ongoing and seemingly indefinite use of overtime is not an efficient use of state resources. DMHMRSAS Central Office should review this staffing pattern closely with SWVTC staff.

DMHMRSAS Response: As result of the collaborative reviews conducted regarding the use of overtime, SWVTC has hired temporary and part-time employees instead of permanent employees; utilized non-direct care employees in service provision; kept other than direct care service positions vacant in order to generate funds for direct service; lowered direct care coverage when client safety allowed and consolidated supervision/managerial duties to create additional direct care staffing. All of these efforts, and many others have been helpful, but are not adequate to meet all staffing needs. Central Office is presently reviewing staffing needs related to the next biennium budget request.

6 Month Status Report: 01/01/02
The addition of one-time funding for staffing has helped to reduce overtime. Overtime use has been reduced from an average of 95 hours per day to 32 hours for the month of November, a 67% reduction in overtime use. Additional reductions are expected when 29 recently employed Human Care Service Worker's complete pre-service training.

OIG Comment - Interviews with administrative and direct care staff reflected the benefits the facility have experienced from the additional funding provided, which enabled the facility to hire a number of temporary full-time employees with benefits, adding significantly to the workforce. These positions have resulted in a dramatic drop in the use of overtime. As there was a question regarding the continued availability of these positions because of budget concerns. This finding remains ACTIVE.

6 Month Status Report: 07/01/02
Overtime continues to be reduced from the levels at the time of the IG survey. During the past 9 weeks there has been an increase due to several behavioral and medical resident conditions and increased leave demand during warm weather months. Overtime has averaged 51 hours per day for this period-a 50% reduction since the time of the IG survey but an increase of 19 hours per day since the last report. When the acute resident need problems are corrected, we should see a return to the 30 to 35 hours per day range of Nov. 01 through April 02. SWVTC received official word 5/29/02 that the additional funds received in Nov. 01 have been approved for the FY 03/04 budget.

Finding 3.7: There is a shortage of key staff in several key professional positions.

Recommendation: Review staffing patterns and functions to determine optimal levels required to effectively implement and follow-up on active treatment needs of the residents and provide adequate supervision of staff for optimal facility operations. This may not be able to be enhanced effectively without an increase in staffing.

DMHMRSAS Response: SWVTC has hired temporary and part-time employees instead of permanent employees, utilized non-direct care employees in service provision, kept other than direct care service positions vacant in order to generate funds for direct service, lowered direct care coverage when client safety allowed and consolidated supervision / managerial duties to create additional direct care staffing. All of these efforts and many others have been helpful, but not adequate to meet all staffing needs. The facility continues to review staffing patterns and utilization to determine optimal level based on their current staffing levels. Plans identifying SWVTC staffing needs to meet NVTC/DOJ levels have been submitted to Central Office by the facility with its last submission on July 24, 2001.

6 Month Status Report: 01/01/02
Additional one-time funds have resulted in improvements in HCSW's staffing patterns. SWVTC is in the process of attempting to hire a Family Nurse Practitioner and Two RN's.

OIG Comment - Interviews with administrative staff revealed that the facility has established hiring priorities as funding becomes available. As previously noted, the facility has focused on hiring direct care workers. The current plan is to hire a nurse practitioner to support the work of the facility physician. There is also some consideration regarding the hiring of additional nurses. These positions are contingent on continued funding. This finding is ACTIVE.

6 Month Status Report: 07/01/02
A Family Nurse Practitioner has been hired to support the work of the physician. In addition, two additional nurses have been hired and will begin work in June 02. The facility believes they will be able to add a .5 FTE activity therapist at the start of the fiscal year and are hoping to find the funds to add a full time Ph.D. Psychologist.

Finding 3.8: The facility has used the combining of several key administrative positions in orders to stretch resources.

Recommendation: SWVTC work with Central Office in reviewing this practice to assure effective coverage of key functions, particularly the supervision of staff.

DMHMRSAS Response: SWVTC will continue to review utilization of current staff, however, direct care staff receives priority in recruitment and hiring. In 2000, SWVTC reorganized its staff responsibilities to create the positions as indicated through its collaborative reviews with DMHMRSAS. Reorganization allowed them to designate one staff person as a full time Risk Manager and one person to provide part of his time to complete Abuse/Neglect investigations. They have also consolidated supervision in the residential living units that allowed them to hire a Physical Therapist, a Physical Therapist Assistant, an Occupational Therapist, and an Occupational Therapist Assistant. These changes have resulted in improvements in their risk management program, abuse/neglect investigation process, physical and occupational therapy.

6 Month Status Report: 1/01/02
The facility has hired a Nurse Practitioner. The Nurse Practitioner will begin employment in February and will she will assume the role of Director of Nursing, which will relieve the Medical Director.

OIG Comment - Interviews with administrative staff revealed that the facility has established hiring priorities as funding becomes available. As previously noted, the facility has focused on hiring direct care workers. The current plan is to hire a nurse practitioner to support the work of the facility physician. There is also some consideration regarding the hiring of additional nurses. These positions are contingent on continued funding. This finding is ACTIVE.

6 Month Status Report: 07/01/02
A Family Nurse Practitioner and two additional nurses have been hired. The FNP supports the work of the physician and serves as Director of Nursing. If the facility is to find funds for a Ph.D. Psychologist, this position will have a resident caseload and serve as Director of Psychology.

Finding 4.1: SWVTC has initiated an extensive nutrition management program for every resident.

Recommendation: This program is well organized. Consideration needs to be given to increasing qualified staff so that the Director is able to conduct increased training, follow-up and monitoring of the program. Secretarial support would also be beneficial so that staff resources can be used with the residents.

DMHMRSAS Response: Consideration has been given to additional staff positions for this project. SWVTC has not been able to accomplish this objective because of other higher staffing priorities. As indicated in 3.5 and 3.8 above, numerous strategies have been employed to increase direct service provision (including nutritional management). These actions have enhanced nutritional management services. As indicated previously, plans identifying SWVTC needs to meet NVTC/DOJ requirements have been submitted to Central Office. The Department continues to track staffing needs at all training centers and is currently developing a staffing package for the purpose of bringing all training centers up to DOJ staffing recommendations.

6 Month Status Report: 1/01/02
As indicated previously, plans identifying SWVTC needs to meet NVTC/DOJ requirements have been submitted to Central Office. The Department continues to track staffing needs at all training centers and has currently developed a staffing package for the purpose of bringing all training centers up to DOJ staffing recommendations, which has been submitted to DPB. There are 29 full-time HCSW's positions hired by the facility and one Family Nurse Practitioner. Not all of the staff has started work at the facility but all of them have accepted the offer.

OIG Comment – Interviews with administrative staff revealed that the facility continues in its efforts to secure the necessary funding needed to allow the facility to meet the staff patterns established by the settlement agreement between the DOJ and the Commonwealth at NVTC. As previously noted, the facility has used the additional funding to hire additional direct care workers and a nurse practitioner. This finding is ACTIVE.

6 Month Status Report: 07/01/02
See 3.7 and 3.8 above for report of new efforts to try and achieve staffing patterns of the DOJ agreement.

Finding 4.2: The staff at SWVTC maximizes its efforts to provide active treatment despite staffing limitations.

Recommendation: Evaluate the need for increased professional staff and/or aides trained in conducting OT and PT activities. Consider arranging for a secretarial person to support professional staff enabling them to work more efficiently. Increase opportunities for developing programs that may assist residents in optimizing their ability to return to the community.

DMHMRSAS Response: SWVTC will continue to maximize its efforts to provide active treatment despite staffing limitations. As indicated in 3.8 above, SWVTC has been able to add one Physical Therapist, one licensed Physical Therapy Assistant, one Occupational Therapist, and one Occupational Therapist Assistant by combining supervision/managerial responsibilities. The Occupational Therapist is reviewing the use of sensory stimulation and will modify the concept based on that review.

6 Month Status Report: 1/01/02

An additional sensory stimulation activity room has been completed and is in use. In addition to the activity described in the response, Active Treatment Monitoring has been increased with 30 monitoring sessions scheduled each month. This is done by the Hospital Director, Unit Managers, and Team Leaders.

OIG Comment – Interviews with administrative staff revealed that the facility continues in its efforts to secure the necessary funding needed to allow the facility to meet the staff patterns established by the settlement agreement between the DOJ and the Commonwealth at NVTC. As previously noted, the facility has used the additional funding to hire additional direct care workers and a nurse practitioner. Other professional staff additions will be completed as funding becomes available. The facility has reviewed the current program offering and made some changes including the use of sensory stimulation activities. This finding is ACTIVE.

6 Month Status Report: 07/01/02
One more Sensory Stimulation room was completed (in May 02) since the last report and is now in use. Active Treatment Monitoring checks continue to be conducted as described in the 01/02 report. Physical management training for all direct care employees has been completed effective 5/02. The facility has not yet been able to secure the funds needed to add PT/OT or Speech/Language staff.

Finding 5.1: There is one FTE of primary care staff at SWVTC.

Recommendation: Pursue the hire of a second FTE primary care provider for the residents at this facility.

DMHMRSAS Response: SWVTC will continue to review the utilization of current staff in collaboration with Central Office. Human Service Care Workers (HSCWs) will receive priority in recruitment and hiring. This priority precludes hiring an additional primary care physician position at this time. However, SWVTC has attempted to enhance primary physician services by contracting with a local physicians group to serve as attending physicians when a SWVTC client is admitted to the local regional hospital. This contract also has a provision that the group provides back-up medical coverage for the facility physician if he is on extended leave.

6 Month Status Report: 1/01/02
SWVTC contracted with a local physicians group to provide services in December 2000. These physicians provide services to SWVTC clients in the facility and follow them when admitted to the community hospital. Also, as part of the contract the physicians provide peer review.

OIG Comment – Interviews with administrative staff revealed that the facility continues in its efforts to secure the necessary funding needed to allow the facility to meet the staff patterns established by the settlement agreement between the DOJ and the Commonwealth at NVTC. The

facility has contracted with a group of physicians to provide coverage during the absence of the primary medical providers at the facility. These physicians provide peer reviews, as needed. This finding is ACTIVE.

6 Month Status Report: 07/01/02
SWVTC has now hired a Family Nurse Practitioner to support the work of the primary care physician. The contract with the physician group also remains in effect.

Finding 8.1: Staff interviewed identified the required amount of regular mandatory overtime as the primary factor in increased job dissatisfaction and low morale.

Recommendation: SWVTC works with Central Office in reviewing the adequacy of direct care positions with a goal of addressing areas of staffing shortages.

DMHMRSAS Response: SWVTC will continue its efforts to maximally utilize available staff. See 3.5, 3.8, 4.1, 5.1, 5.2 and 5.3 for demonstrated examples of SWVTC's efforts to increase direct service staffing. In addition, creative methods for working overtime when needed have been developed (i.e., Employees can and do "split" overtime shifts so that two or more employees can cover an eight hour absence. When overtime is needed, employees are polled to determine who would be willing to work the overtime before anyone is mandated to work over. An employee who volunteers to work overtime has his/her name moved to the bottom of the mandatory overtime list. Professionals/managerial staff are sometimes utilized to take clients to medical appointments, off-campus shopping, etc.). But overtime is still required daily to meet all client service needs. Central Office is presently reviewing the staffing needs of all the training centers, including SWVTC, for the next biennium budget.

6 Month Status Report: 1/01/02
Refer to section 3.5 response. Overtime has been reduced by 67% as a direct result of additional one-time funds and will be reduced even farther when 29 newly hired HCSW's complete pre-service training.

OIG Comment - Interviews with direct care staff reflected a significant change in the morale since the previous inspection at the facility. Staff related that there was less overtime, which enabled them to feel more confident in being able to meet important personal commitments. This has resulted in staff feeling more positive about their jobs and SWVTC as an employer. Although many expressed being pleased by the recent hiring, they also expressed concern regarding whether the gains could be sustained because of funding issues. This finding remains ACTIVE.

6 Month Status Report: 07/01/02
Refer to section 3.5 response. The 29 HSCW positions were filled by 2/02. This has resulted in a dramatic reduction in overtime levels from the time of the initial IG survey. SWVTC received official word 5/20/02 that the funds added in November 01 have been approved for continuation in the FY03/04 budget.

SOUTHWESTERN VIRGINIA TRAINING CENTER
RESPONSE TO SNAPSHOT INSPECTION REPORT
December 2 & 3, 2001
OIG REPORT #50-01

Finding 2.1: Overtime hours have significantly decreased over the past few weeks.

Recommendation: This facility cannot continue to function without adequate numbers of staff.

DMHMRSAS Response: SWVTC overtime hours continue to remain at lower levels. They were approximately 100 hours per day in April 2001 and are presently down to approximately 33 hours per day during the month of December and remains between 30-40 hours per day. The ability to maintain these lower overtime levels and still maintain quality services is directly liked to the funding that was allocated in the 2002 budget.

6 Month Status Report: 07/01/02
Overtime continues to be reduced since the time of the initial IG survey. There has been an increase from the 30-40 hour per day range to an average of 51 hours per day for the past 9 weeks because of acute resident behavioral and medical needs and warm weather leave demands. Overtime should return to the 30-40 hours per day levels when the acute resident needs are met. SWVTC received official word 5/29/02 that the funds added in Nov. 01 to assist with staffing problems were approved for the FY 03/04 budget.

Finding 2.2: Staff verbalized an increase in morale over the past several months.

Recommendation: Look for opportunities for staff participation as practices of leave time use and self-scheduling are being discussed.

DMHMRSAS Response: Increase in morale is a result of the enhanced staffing noted in other findings, thus allowing for a reduction in overtime and more opportunities for leave usage. The SWVTC Coverage Committee is utilized for planning and review of leave/scheduling practices for HCSW's. HCSW representatives from each unit and shift who are members of this committee will be sent to all living units to ensure that HCSW's are aware of issues being discussed and have the opportunity to provide input through their representative or through unit supervisors.

6 Month Status Report: 07/01/02
Refer to 2.1 above for status report. Coverage Committee continues to meet. Approval of the additional funds for the upcoming budget year should help assure employees that the additional staffing levels will continue. Correction of the acute resident medical and behavioral problems will allow for a reduced need for "one-to-one" HSCW's.

Finding 2.3: At best, the current staffing patterns are marginally adequate.

Recommendation: This critical situation will need to be addressed. Continue to work with the Central Office to assure adequate staff coverage.

DMHMRSAS Response: See 2.1 above. The funds added to the facility's budget this Fiscal Year (2002) have been requested for the upcoming Fiscal Years. The ability to continue the present staffing levels described in the IG's report and the ability to increase staffing levels are directly linked to the facility's last appropriation.

6 Month Status Report: 07/01/02
SWVTC has acted upon the additional funds received in Nov. 01 relative to staff hires.

Finding 2.4: Review of five charts revealed that there has been considerable gap in access to a psychiatrist.

Recommendation: This gap in access to a psychiatrist should be brought to the attention of the Central Office so that assistance for this situation can be addressed through the state facility medical directors.

DMHMRSAS Response: SWVTC gap in psychiatric services was brought to the attention of the Central Office Medical Director. SWVTC has an addition of contracts for the services of two psychiatrists, services are being provided and clients are seen in a more timely manner. If the situation were to recur, the Central Office will be notified again. With two psychiatrists under contract, a backup should be available even if one of the psychiatrists was unable to provide service.

6 Month Status Report: 07/01/02
The two contract psychiatrists have been coming to SWVTC on a regular basis, there has not been a repetition of the service gap noted during the last IG visit.

Finding 3.2: Daytime activities demonstrate the facility's effort to maximize active treatment.

Recommendation: Continue to review and deploy staff in the most effective manner for maximizing active treatment opportunities for the residents.

DMHMRSAS Response: SWVTC managers will continue to review resource allocation on an almost daily basis in efforts to maximize opportunities for active treatment. The facility currently has two new projects; they are the Falls Management Program and increased contract work in the vocational area. The Falls Management Program is a new project, and leadership is provided by one of the Facility Project Managers. There is a cross of disciplines participating, which includes Occupational Therapy and Physical Therapy. The program will monitor fall

types and solutions to lower the fall risk. The vocational contract is for one year with a local company approximately 12 miles from the facility in North Carolina. The residents sort socks by style, size, etc.

6 Month Status Report: 07/01/02
Both projects described above are continuing. The sock contract has been expanded and space has been added to accommodate the increased work. A car washing component has been added to the supported employment program. In the planning/development stage is a project involving residents servicing on-campus drink machines.

WESTERN STATE HOSPITAL
AUGUST 11, 1999
OIG REPORT # 8-99

Finding 2.3: The Medical Center building was deserted and very institutional in appearance, but was clean and well maintained.

Recommendation: Staff and long-term patients on this unit may want to look at short-term, inexpensive ideas that might give the unit a more domestic appearance.

DMHMRSAS Response: The treatment team on Medical Center will be given this task to address and provide recommendations to the Medical Director by December 1, 1999.

6 Month Status Report: 7/1/01
Minor improvements have been made subsequent to this report including posters and more personal items.

OIG Comments - Interviews revealed that staff did consider ways to make this setting appear less institutional. Minor improvements have been made. The unit still has the pony walls, which limits the decorating options. This finding is ACTIVE.

6 Month Status Report: 01/01/02
Staff of WSH have utilized artificial flowers, pictures, family pictures of the patients, posters, stuffed animals, seasonal bulletin boards, and calendars in addition to patient art work and crafts to improve the overall appearance of the unit.

OIG Comments- The team toured the unit during the March 2002 inspection and noted that efforts have been made to make the unit appear less institutional by the addition of artwork and

personal items. Along with the change in function on this unit, opportunities for increased interaction between the staff and patients are available. It is anticipated that as this unit continues to evolve, additional activities will be added. This finding is ACTIVE.

6 Month Status Report: 07/01/02
WSH has appointed a Performance Improvement Team to evaluate ways to improve the interior décor of the wards. This group will also evaluate whether wards can team up with Volunteer groups year round instead of only for holidays. More fully developed recommendations will be due to Administration in October 2002.

WESTERN STATE HOSPITAL
SNAPSHOT INSPECTION REPORT
MARCH 7, 2002
OIG REPORT #57-02

Finding 1.1: Overall the facility was clean and well maintained.

Recommendation: Continue efforts to make this very institutional setting more comfortable.

DMHMRSAS Response: We will appoint a Performance Improvement Team to make fiscally responsible recommendations to improve the attractiveness of the ward settings, including patient bedrooms, visitor's rooms, and common areas. Draft recommendations will be available by July 1, 2002 for Executive Staff review and the development of implementation plans. Depending on the nature of the recommendations we would expect to have completed the first phase by October 1, 2002.

6 Month Status Report: 07/01/02
Because of the facilities focus on Department of Justice site visits the Performance Improvement Team draft recommendations will not have recommendations available until October 1, 2002. As that time based upon fiscal responsibility project phases will be delineated.

Finding 1.3: Coordinating the logistics of the treatment activities for the patients who go to the treatment mall from a residential unit one or more times a day is challenging.

Recommendation: Staff should explore methods for streamlining communication and care of patients that continues to foster independent functioning, but also reduces risk to patient safety and facility liability.

DMHMRSAS Response: This is an issue of ongoing concern to us as well and adjustments have been made as the program has evolved. The PSR Steering Committee will assess ongoing

problems in this area for discussion of potential changes by July 1, 2002. Minor adjustments will continue to be made as needed during the interim.

6 Month Status Report: 07/01/02
In general, the system of photo IDs, walkie-talkies, PSR Assistants doing hall and door monitoring, and the multiple components of the electronic database have proven to be effective in maintaining security while providing active treatment. Adjustments are made on a case by case basis when indicated.

Finding 2.1: Staffing patterns were adequate to meet the care and treatment needs of the residents.

Recommendation: Continue to provide the level of staffing necessary for addressing both the care and treatment needs of patients.

DMHMRSAS Response: No change will be made in the NHPPD, RN percentage of NHPPD, and RN per ward per shift standards we have achieved. All budgetary decisions will preserve the FTEs required to maintain the current level of staffing.

6 Month Status Report: 07/01/02
Overall NHPPD, RN percentage of NHPPD, and assignment of an RN to each ward for each shift have been met for April, May, and June 2002.

Finding 2.4: In the Stribling psychosocial programs, there is no direct participation of members of the social work department and minimal involvement of the psychiatrists.

Recommendation: Review the present complement of staff involved with the Stribling program. Consider the role of social worker and psychiatric staff to further enhance this program.

DMHMRSAS Response: Currently, members of the Social Work department provide 41.5 hours of PSR interventions each week. In addition, we assigned one SW to the PSR staff during its initial development and this person provides 20 hours per week (but would not appear as a SW in the schedule). Psychiatrists are expected to deliver two hours per week, but personnel changes during the past year have resulted in that being less than required overall. We expect to be fully staffed with P3 psychiatrists no later than mid-July. Discussions with the Medical Director and Social Work Director concluded with the basic assessment than this is a reasonable requirement in light of the other duties of these individuals at this time, but that we will continue to assess the situation depending on census and turnover.

6 Month Status Report: 07/01/02
WSH has made no changes to the requirements of members of these two departments noted in prior response. They have initiated a process in the Social Work

Department to co-lead groups with a CSB representative from Region Ten. This pilot will be evaluated relative to extension.

Finding 2.5: Facility administration is developing a plan to make routine medical care available in the actual psychosocial treatment mall so as a minimize disruption to treatment.

Recommendation: Incorporate this service as planned.

DMHMRSAS Response: This is an integral part of our overall restructuring of both the Medical Care service and our Transportation/Escort services. Dr. Gwendolyn Lee arrives July 8, 2002 as our Director, Primary Care services and this will be one of her first projects. Expect to have fully operational by October 1, 2002. The Primary Care Services staff will be encouraged to use the examination rooms proximal to the PSR treatment areas in the interim.

6 Month Status Report: 07/01/02
The Director of Primary Care Services is anticipated to be on duty at WSH beginning July 10, 2002. It is still anticipated that routine medical care will be provided in the Psychosocial Treatment Mall by October 2002.

Finding 3.1: Patients are provided with a variety of active treatment options depending upon their psychiatric and medical stability.

Recommendation: Continue to provide a variety of treatment options for the patients needs. Consider a mechanism for evening activities to be available to the patients on the Medical Center.

DMHMRSAS Response: The Director of Nursing and Director of Rehabilitation Services will meet with the Medical Center treatment team to determine what types of activities would be indicated and the best way to provide them with a target date of July 1, 2002 for implementation. This is the next step in the evolution of this ward from a general medical unit to one providing psychiatric services to individuals with significant medical problems and nursing care needs.

6 Month Status Report: 07/01/02
Individual cases have been reviewed by the treatment team in conjunction with Rehabilitative Services for additional evening activities to be available on the Medical Center. These have been implemented when indicated.